FINDING WHAT WORKS IN A COMPLICATED TRANSITION: CONSIDERATIONS FOR SOLDIERS WITH PTSD AND mTBI

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This study specifically focuses on the Army separation process and the positive and negative characteristics of the process, which impact soldiers diagnosed with PTSD and mild TBI.

Separation from the military is a major life change that is often stressful and overwhelming. Soldiers clinically diagnosed with PTSD or mild TBI, face an uphill battle in managing, processing, and coping with life changes and stress. Major trends within the veteran population correlate PTSD to homelessness, suicide, and unemployment; these issues may be indicative of a transition process that does not account for behavioral health diagnosis of PTSD and mild TBI.

This thesis deconstructs the separation process in order to identify pitfalls and possible points for success. Data for this study was obtained by interviewing Veterans Affairs (VA) case managers who deal directly with the transition of active duty soldiers with combat-related disabilities.

The results of this study lay out the transition process in which a soldier is medically separated from the Army and moves into the VA health care system. It highlights the importance of coordination between DoD and the VA; the case manager's impactful position; negative financial impacts, and soldiers' responsibilities to create a successful transition.

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The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.)

ABSTRACT

FINDING WHAT WORKS IN A COMPLICATED TRANSITION: CONSIDERATIONS FOR SOLDIERS WITH PTSD AND mTBI, by Mai Lee E. Eskelund, 164 pages.

This study specifically focuses on the Army separation process and the positive and negative characteristics of the process, which impact soldiers diagnosed with PTSD and mild TBI.

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CF was the inspiration for the topic.

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TABLE OF CONTENTS

Page

ACRONYMS

ACAP	Army Career and Alumni Program
DoD	Department of Defense
DSM-IV (TR)	Diagnostic and Statistical Manual version IV (Text Revision). Published by the American Psychiatric Association, provides common language and standard criteria for classification of mental and behavioral health disorders.
IDES	Integrated Disability Evaluation System
IED	Improvised Explosive Devices
MEB	Medical Evaluation Board
mTBI	mild Traumatic Brain Injury
MTF	Medical Treatment Facility
NMS	National Military Strategy
NSS	National Security Strategy
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PEB	Physical Evaluation Board
PTSD	Post Traumatic Stress Disorder
RIF	Reduction in Force
RPG	Rocket Propelled Grenade
TAP	Transition Assistance Program
TBI	Traumatic Brain Injury
VA	Veteran Affairs

ILLUSTRATIONS

Page

TABLES

Page

CHAPTER 1

INTRODUCTION

> The Department [of Defense] must do all it can to take care of our people-physically and psychologically. The health of the All-Volunteer Force depends on substantial and enduring efforts to track and improve physical and mental health, readiness, family support, and leader development programs across the force.
>
> — *Quadrennial Defense Review Report,* February 2010

Introduction

Presidential directives, Congressional mandates, and the Department of Defense have all identified the national and strategic importance of providing proper behavioral health care services to veterans, wounded warriors, service members, and military families. Major mental health conditions stemming from over 12 years of combat operations can result in issues such as Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD). Petska and Maclennan (2009) categorize the combination of mild TBI (mTBI) and PTSD as a signature injury for service members returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).

The concept of PTSD has been congruent to war for centuries. The Iliad, composed as early as 800 B.C., describes the psychological turmoil of Achilles, presenting compatible concepts and strong linkages to modern psychology's definition of PTSD and PTSD symptoms (Schiller 2003; Shay 2003). PTSD is a mental, behavioral, physiological, and physical reaction or response to a traumatic stressor. In the majority of cases, PTSD develops shortly after a traumatic event, however may not fully develop (or may be repressed) for months or even years (Bryant and Harvey 2002). PTSD commonly occurs with other disorders to include anxiety, mood, and substance use disorders (Taylor

2006, 23). There is a strong correlation between battle injuries (traumatic stressors) and rates of PTSD and other behavioral health concerns (MacGregor et al., 2009).

A common physical battle injury from both the Iraq and Afghanistan Theater is the TBI. TBIs present structural or physiological disruption of brain function due to an external force (Clark 2014, 58). Blast related injuries caused by improvised explosive devices (IED), rocket propelled grenades (RPGs), and land mines are prominent weaponry during OIF and OEF and are the three leading causes for TBI (Brain Injury Association 2014). There are four levels of severity for a TBI: mild, moderate, sever, and penetrating. Mild TBI (mTBI) is the most common TBI.

United States Army soldiers who are officially diagnosed with TBI and PTSD may be referred to the Integrated Disability Evaluation System (IDES) to conduct a Medical Evaluation Board (MEB) and possibly a Physical Evaluation Board (PEB). The MEB is an informal process to determine if the medical issue (i.e. TBI/PTSD) restricts the soldier from performing his or her military duties listed and in accordance with Army Regulation (AR) 40-501. The MEB refers a soldier who does not meet retention standards to a PEB, which decides if a soldier is fit for continued service. A soldier who is no longer fit for duty is then eligible for disability benefits and a preliminary VA disability rating will be assigned. Upon completion of the administrative evaluation boards, the Transition phase of the IDES process occurs. The entire IDES process will be depicted further in Chapter 2, the Literature Review.

If separation is necessary, the Transition Phase allows a Soldier to out-process, retire, or separate from the Army within a 90-day period and thus; the soldier is officially released or discharged from the military. Separation out of the Army is a major life

change for the average soldier and it may be an extremely stressful process. Being released from the Army through a medical transition process may be even more grueling to a soldier who is diagnosed with PTSD and or mTBI. It, therefore, becomes critical to examine the necessary steps that a veteran must take to make a successful transition into civilian life, while simultaneously dealing with TBI and or PTSD.

Background

"Regardless of gender or combat occupation specialty, today's combatants all have one important bridge to eventually cross after their war is over. . . . That is to come home" (Cantrell and Dean, 2007, xiii). It is common for military members and military families to conduct Permanent Change in Station (PCS) on average every three years, making military members and their families accustomed to transition. A new military assignment brings about new schools for the children, new jobs and communities for the spouse, and new challenges to face. Military communities are designed to provide support and programs, which aim to aid in soldiers' transitions. Housing information, school districts statistics, and local community information are often available at numerous on-post facilities, Military One Source, and online sites such as militaryinstallations.mil. The military community is able to provide support that is often superior to civilian communities and civilian transition (Clark 2014, 44).

Military service and associated experiences provides military members with skill sets that can help with the transition into civilian life. Military Occupation Specialties provide expert training in one of over 150 different jobs within the Army active duty (Department of the Army 2014c). Additional to specific skill sets, day to day life-skill training is developed such as time management, teamwork, and mission accomplishment.

These skills and knowledge assist into transitioning out of the military and are useful in the civilian workforce and life. However, not all soldiers transition out of the military under normal circumstances. Unfortunately, many soldiers have "invisible wounds of war" (Tanielian and Jaycox 2008) and carry these wounds with them into their civilian life.

The transition from military to civilian life often encompasses assessing medical benefits and entitlements, being financially prepared for the transition, finding a new job and or continuing education, moving to a location, transitioning into the VA system and finding and continuing treatment for documented disabilities (Army Career and Alumni Program 2014a). Each military service, to include the Army, has created programs that provide services to assist in finding a job, applying to an education institute, and transition into the VA; however, "Numerous psychological studies have found that the social support system-or lack thereof- upon returning from combat is a critical factor in the veteran's psychological health" (Grossman 2009, 279). With soldiers who already experience a decrease in psychological health, the need of a strong support system becomes essential during the transition of a service member who has been medically discharged due to TBI and PTSD.

This study researches the current transition process an active-duty Army soldier undergoes after the completion of a MEB and PEB. Specifically, it aims to examine positive trends, which may lead to a successful transition, as well as negative trends, which may provide insight and issues to avoid that lend to poor transition to civilian life. This research seeks to gain insight into improving the transition process for soldiers diagnosed with TBI and PTSD as they transition into civilian life.

Research Question

The primary research question of this research is, "What factors facilitate positive behavioral health and a successful transition into civilian life for Soldiers undergoing a medical and physical evaluation board diagnosed with mild Traumatic Brain Injury and Post Traumatic Stress Disorder separating from active duty service?" To answer this question the following secondary questions are of vital importance:

1. What is the existing process for members separated for behavioral (PTSD and mTBI) health issues?
2. What are Case Managers' (Army and VA) responsibilities and actions that facilitate a successful transition?
3. What soldiers' and veterans' actions facilitate a successful transition?
4. What are common trends and or issues that improve or impede behavioral health healing for Soldiers?
5. What actions by the Behavioral Health Providers facilitate a successful transition?

Assumptions

There are three key assumptions to this study. The primary assumption is that the transition process is multifaceted and affects the life of a service member who is transitioning out of the military into civilian life in multiple ways to include, but not limited to: work, family dynamics, social interactions, cultural aspects, and psychological implications. This paper will not research every transitioning aspect, but will have information pertaining to several. Recommendations for continued study in each sector is presented in chapter 5, Recommendations for Future Study.

The second assumption is that case managers and behavioral health providers keep the soldier's best interest and provide the best support possible. Those within the health care field are responsible to uphold a medical code of ethics, the Hippocratic oath, which dictates an ethical standard of behavior and rules in which to conduct behavior (American Psychological Association 2014). Case managers and behavioral health providers must uphold ethical and fair treatment, supporting the assumption that they seek to help patients to the best of their ability.

Finally, it is assumed for the purpose of this study that soldiers diagnosed with mTBI and PTSD will continue treatment during their transition process and until a professional designates treatment is no longer needed. The assumption is that a successful transition to civilian life means that the soldier completes the designated process while continuing treatment for TBI and PTSD. This assumption does not address the veterans who are not officially diagnosed with PTSD or have PTS symptoms.

Definition of Terms

The terms service member, military member, soldier and veteran, will be used interchangeably.

Active Duty–Military members who are not Reserve or National Guard components, which includes Army, Air Force, Navy, and Marine services.

Combat Veteran–Military members who have served on or after January 28, 2003, on active duty in a theater of combat operations and have been discharged under other than dishonorable conditions (Department of Veterans Affairs 2011).

IDES–For the purpose of this research IDES refers to the five phase medical process used to evaluate the retention and disability of a soldier. The MEB and PEB are innate to this definition.

PEBLO–Physical Evaluation Board Liaison Officer is the principal point of contact between the soldier and the MEB and PEB of IDES (Army Medicine 2014a; Army Medicine 2014b).

Transition–For the purpose of this study, transition and separation are both used to define the process that a service member executes to officially depart from active duty military service under honorable conditions.

VA Case Manager–Nurses or social workers who coordinate patient care and activities which assist in navigating the veteran through the VA system (Department of Veterans Affairs 2014).

Limitations

The quantity of interviewees is the primary limitation of this research. The quantity of VA case managers interviewed was limited because of time. The information provided by the case managers was qualitative in nature and had bearing on the subject. Additionally, due to the sensitive and personal nature of this study, only one veteran was interviewed. The veteran has been diagnosed with PTDS, however was not separated through the IDES process. The veteran interview was relevant to the study because it provided first hand information on the impact of a separation on a soldier with PTSD.

Additionally, the main military population studied was the U.S. Army. Each respective service (Air Force, Navy, and Marines) has a separation process; however, because Fort Leavenworth provided many of the resources and interviewees, the thesis

focused on the U.S. Army. Veterans, regardless of service affiliation may face similar issues upon separation from the service, and will be briefly discussed in chapter 5, Recommendations for future study.

Finally, the symptoms of mTBI such as sleep disturbance, cognitive impairments, fatigue, and mood disorder overlap with the symptoms of PTSD. Due to these overlapping symptoms, there may be a larger generalization of results falling within the PTSD diagnosis and less identified with TBI. PTSD and TBI will be discussed in detail in chapter 2, Literature Review. It is a limitation because TBI symptoms are not easily distinguishable with PTSD and may hinder proper diagnosing and treatment.

Scope and Delimitations

The scope of the study assesses the transition process for active duty soldiers within the parameters of being medically discharged due to a diagnosis of TBI and PTSD. The study identifies trends seen by the professional community of case managers in order to identify positive and negative trends that impact recovery and the transition process. The analysis will identify the importance of each identified trend and identify ways in which to aid or mitigate the outcome.

This study was conducted in Fort Leavenworth, Kansas, and represents only one location. Other DoD and VA institutes may result in different information due to a difference in population, location, and coordination between DoD and VA institutes. This delimitation is further addressed in chapter 5, Recommendations for future study.

Although there are multiple cultural, social, and psychological factors that interact and play a part in any transition, this study does not present extensive arguments on the cultural and social factors, which play a role during transition. Additionally, nearly half

of the deployed combat personnel are from the Reserve component. Research shows that Reserve components' transition experience is often difficult because of the quick transition back to civilian careers and life (Clark 2014, 2, 35). Instead, this study will focus on the Active duty component in order to focus on one sample group. Finally, this study acknowledges that behavioral health issues span a wide range of symptoms and diagnosis. TBI and PTSD are increasing in numbers but only represent two behavioral health diagnosis.

Significance of the Study

Vietnam veterans know and understand the difficulties that come from transitioning back from war to civilian life when suffering from PTSD (Dixon 2008, 8). With a new group of veterans emerging from the Global War on Terrorism (GWOT), this study seeks to highlight the importance of the transition into civilian life. Additional physical and mental stressors and injuries are now accompanying over 40 percent of our force, which must be taken into account while transitioning out of the military. The datum gathered seek to provide insights into challenges, difficulties, and possibilities that case managers and soldiers alike can use in order to make a more successful transition during a trying and difficult time.

Summary

Chapter 1 provided an overview of government acknowledgement of the national importance to provide care for Veteran's, Wounded Warriors, Service men and women, and military families. Previous research shows that TBI and PTSD are occurring at a high rate, and it thus is important to study these injuries in relation to the care provided and the

transition that occurs after being released from the service into civilian life. Discussion in this chapter identified the need to know and understand the current process in order to identify keys to success and possible issues that arise in the transition process. Chapter 2 provides a review of TBI and PTSD and the current process that service members go through while being medically boarded out of the military. Finally it will provide an overview of the current steps identified in a "typical" transition in order to understand the process.

CHAPTER 2

LITERATURE REVIEW

Introduction

On October 7, 2001, the Global War on Terror (GWOT) began with Operation Enduring Freedom (OEF) in Afghanistan and continued into Iraq on March 20, 2003 with Operation Iraqi Freedom (OIF). Combat operations in Iraq ended on September 1, 2010 and Operation New Dawn (OND) was formed to advise Iraqi security forces, with the final withdrawal of the military on December 15, 2011 (Fischer 2014, 4). Today, OEF is still ongoing with estimated withdrawals projected for the end of 2014. A limited force may remain to train, advise, and assist Afghan forces, which is dependant upon Afghanistan signing a bilateral security agreement (Starr and Cohen 2014). This amounts to over twelve years in combat operations two different theaters supporting OEF, OIF, and OND (table 1).

About 2.5 million service men and woman serving across all services (Army, Navy, Marines, Air Force, Coast Guard) and components (Active Duty, Reserve, and National Guard) have deployed to either Iraq of Afghanistan in support of OIF, OEF, and OND. More than a third of that total, have been deployed more than once, and 400,000 service members have deployed three or more times and served in both theaters (Adams 2013). As of 2012, the VA was tracking a total of 1,663,954 veterans that have deployed, returned, and separated from military service (VBA 2012).

Table 1. GWOT Veterans by Branch of Service

Branch of Service	Reserve Guard	Active Duty	Total
Air Force	119,930	172,391	292,321
Army	459,945	399,484	859,321
Coast Guard	2,013	5,355	7,368
Marine Corps	47,542	172,847	220,389
Navy	43,901	232,653	276,554
Other	12	157	169
Unknown	2,374	4,150	6,524
Total matched to VA systems	675,717	987,037	1,662,754
Unable to match to VA systems	521	679	1,200
Total	676,238	987,716	1,663,954

Source: Veterans Benefits Administration (VBA), *VA Benefits Activity: Veterans Deployed to the Global War on Terror*, November 2012, http://www.vba.va.gov/REPORTS/abr/index.asp (accessed March 12, 2014).

From 2002 to 2011, approximately 1.3 million people have left the military service and a little over half of that population have officially registered with Veteran's Affair's (VA) health care (Martinez and Bingham 2011).

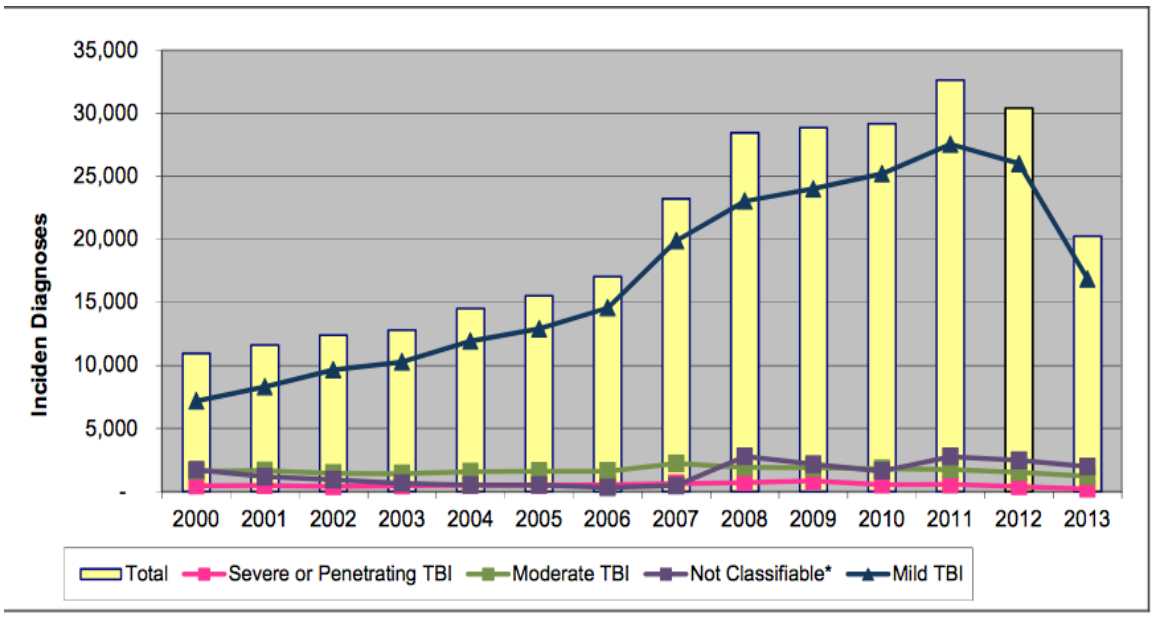
Currently, the supporting numbers for TBI and PTSD vary depending on the source. According to the United States Department of Veteran's Affairs (VA) annual benefits report, PTSD is the third most prevalent service-connected disability for veterans receiving VA compensation (VBA 2012, 5). To be clear, not all veterans have PTSD. Clinical psychologist, Steven Taylor, PhD states, "PTSD is a complex and often chronic disorder. . . . Many people are exposed to traumatic events and yet only a few develop PTSD" (Taylor 2006, 23). Although many combat Veterans may not have PTSD "many of the signs of PTSD can be construed for what military stress teams now call Combat Operational Stress (COS). It has been determined that every participant in a war zone will

manifest some aspects of COS (i.e. hyper-alertness, anxiety, frustration, anger, confusion, intolerance of 'stupid' behavior, sleep disruption, etc.)" (Cantrell and Dean 2007, 8).

Studies have shown an increasing trend in the totals of personnel with PTSD and PTSD symptoms. In 2004, a report by Hoge et al. conducted research on Army soldiers and Marines four months after deployment. Results indicated a 9 percent probable PTSD rate using the PTSD Checklist-Military (PCL-M) (Weathers, Huska, and Keane 1991), which is provided in Appendix A. In 2006, Vasterling et al. examined a smaller population of redeployed soldiers with an increased rate of 11.6 percent (Litz and Schlenger 2009, 1). The RAND study, *Invisible Wounds of War* (2008), estimated that about 300,000 service members had symptoms of PTSD, major depression, and TBI. In 2011, Pew Research Center conducted research on OIF and OEF Veterans and found reported that "44% report readjustment difficulties, 48% [have] strains on family life, 47% [have] outbursts of anger, 49% [have] posttraumatic stress, and 32% [have] an occasional loss of interest in daily activities" (Taylor et al. 2011, 1).

"TBI is a common injury of the wars in Iraq and Afghanistan" (IOM 2013) and Congressional research shows a clear increase in TBI from 2000 to 2011 (table 2).

Table 2. TBI Over Time, 2000 through 2013, Deployed and not Previously Deployed Combined



Source: Hannah Fischer, *A Guide to U.S. Military Statistics: Operation New Dawn, Operation Iraqi Freedom, and Operation Enduring Freedom* (Washington, DC: Congressional Research, February 19, 2014), 3.

Additionally, a recent study by Clark (2014) showed results that stated:

> Two hundred of 235 individuals (85%) who responded had experienced a nearby explosion that could be physically felt, 107 of those had felt it several times. Specifically experiencing an IED explosion near them was reported by 149 individuals (63%); 65 of them had experienced IED explosions several times. One hundred forty eight individuals (55%) had been attacked or ambushed and 78 of them had this happen several time.

The 85 percent exposed to an explosion or IED are then compared to incidents reported by the RAND study, which only reported 22.9 percent of "being physically moved or knocked over by an explosion." The 62 percent discrepancy may imply an increase in IED and other explosions experienced, thus a possible cause for the increase in TBI

numbers. Additionally, the large delta in percentage may be due soldiers under-reporting the blast injury. Soldiers may under-report in order to stay in the battle, or not appear weak for seeking treatment.

Petska and Maclennan (2009) believe that mTBI and PTSD are a signature injury for OEF/OIF service members (Clark 2014, 38). This upward trend of PTSD, PTS symptoms, and TBI identify a growing population. When applying this population to those transitioning out of the military, either due to personal choice, diagnosis, or the RIF, it then become crucial to study the impacts of transitioning out of the military on this population.

In order to grasp a full understanding of the issue, it is critical to know at what level the problem of Veterans transition is understoond. The national government clearly recognizes and identifies the tertiary affects and challenges that the military faces upon returning from combat in Iraq and Afghanistan. The President directed continued research specifically on TBI and PTSD in order to better reduce, prevent, diagnosis, and treat the affected population (Office of the Press Secretary 2012).

National Recognition

The President of the United States, Congress, DoD, and Army remain mindful that men and women have served in over 12 years of war with multiple deployments in Iraq or Afghanistan, which puts strain and stress on both service members and families (Department of the Army 2013, 1). The National Security Strategy (2010) signed by the President, provides Congress, the whole of government, and the nation a common picture and strategic understanding of the security concerns of the nation. The National Security Strategy (2010) identifies the importance of maintaining "the most capable armed forces

in the history of the world" (The White House 2010, 1) maintaining conventional military superiority. The document clearly states that military service men and women are the "most valuable component of our national defense" therefore it is the government's responsibility to support, resource, and care for veterans and military families (The White House 2010, 14).

The National Military Strategy (NMS) (2011) provides guidelines that support the National Security Strategy. Enduring National Interests and National Military Objectives is accomplished through four sub-categories, one of which is Shaping the Future Force. Shaping the future force specifically states:

> We must think and engage more broadly about the civil-military continuum and the commitments embedded within. Just as our Service members commit to the Nation when they volunteer to serve, we incur an equally binding pledge to return them to society as better citizens. We must safeguard Service members' pay and benefits, provide family support, and care for our wounded warriors. We will place increased emphasis on helping our Service members master the challenging upheavals of returning home from war and transitioning out of the military back to civilian life. Through the power of their example, the success of our veterans can inspire young Americans to serve. In all these endeavors, we must constantly reinforce our connection to U.S. values and society. (Joint Chiefs of Staff 2011, 16)

The national government clearly recognizes and identifies the tertiary affects and challenges that the military faces upon returning from combat in Iraq and Afghanistan. Additionally, the government acknowledges the criticality of proper care for veterans and programs that facilitate veterans' smooth transition out of military service (Department of Defense 2012, 7).

In relation to behavioral health, both the NSS and NSM state that major mental health conditions related to combat operations such as Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD) must continue to be researched to reduce,

prevent, diagnosis, and treat the affected population better (Office of the Press Secretary 2012). Several government initiatives have been started to best study and treat behavioral health issues.

In order to help aid and address behavioral health issues, in August 2012 President Obama approved an Executive Order titled Improving Access to Mental Health Services for Veterans, Service Members, and Military Families to increase and improve access for veterans, service members, and military families to behavioral health care services (Kime 2013). The directive addressed providing high quality, mental health services for veterans, service members, and families in the DoD and in veterans' communities. The directive specifies a complete review of all existing mental health programs across military services, measuring the effectiveness of each program in order to best resource effective programs and remove less effective programs (Office of the Press Secretary 2012).

Additionally, the Department of Veterans Affairs was directed to establish a pilot program for contracting mental health services from community-based providers to increase response time effectiveness for veterans (Office of the Press Secretary 2012). This provides recognition that an increased numbers of service members are entering the civilian work force that suffer from behavioral health issues such as PTSD, substance abuse, and depression. Creating a partnership with community support systems expands resources, treatment options, and recovery. To broaden coverage, the directive established service grants may be available to aid veterans who are not eligible for VA or DoD TRICARE healthcare services and eligible veterans will be covered by the Affordable Care Act (ITFMVMH 2013, vi). The Veterans Affairs has also completed the

hire over 1,600 mental health professionals and over 800 veteran peer-to-peer counselors (Kime 2013). Veterans Affairs Secretary Eric Shinseki said. “These newly hired employees, veterans themselves, are uniquely equipped to guide fellow veterans through difficult issues,” increasing the ability of programs to be fully trained and staffed (Kime 2013).

The President’s directive also provided provisions for the National Research Action Plan designed to conduct research to continue studying TBI diagnostic criteria, neurological disorders following TBI, responsible mechanisms for PTSD, and treatment for both TBI and PTSD (Office of the Press Secretary 2012). Additionally, DoD and VA established joint partnership to research mTBI and PTSD (ITFMVMH 2013, ii). The Interagency Task Force for Military and Veterans Mental Health was tasked to make final recommendations at the end of the Fiscal Year for 2014.

The President, Congress, DoD and VA have clearly identified the importance of treating, encouraging, and providing positive behavioral health care for service members. Initiatives, studies, and task forces have been established to research and continue increasing services for wounded warriors and veterans suffering from TBI and PTSD. Documentation also shows the Nation’s leaders support providing aid and assistance with the transition process for military members transitioning out of the military.

It is the DoD’s responsibility to implement policy and procedures concerning mental health services. Congress directed DoD to establish the Recovering Warrior Task Force (RWTF) to assess the effectiveness of DoD policies and programs concerning care, management, and transition of recovering wounded, ill, and injured members of the armed forces (Department of Defense 2011, 1). The RWTF conducts studies across all

services to include Army, Marine Corps, Air Force, Navy, Walter Reed National Military Medical Center, Reserve Components, and the National Guard Bureau. The VA, although not under the DoD, is offered to review and respond to the RWTF reports because of the VA's integral part for medical care of service members. The first report was submitted to the Secretary of Defense on September 2, 2011 and the RWTF continues to provide recommendations and updates annually.

In 2013, the RWTF made 14 visits to 21 installations and VA facilities, and conducted 30 focus groups and 120 onsite briefings. RWTF's intent is to receive the full range of perspectives that affect soldier care and focuses on headquarters level providers, recovering warriors, family members, and installation level perspectives (Department of Defense 2013, 7). RWTF identifies the difference between upper level management perspectives and individuals undergoing treatment perspectives, and seeks to gain a full scope of understanding at multiple levels. RWTF reviewed the DoD/VA transition process, case management, and integration into the VA, analyzing the outcomes and identifying areas for improvement. (All RWTF information can be found on their website.)

Transition outcomes discussed the importance of an integrated electronic health record system. The system is currently being evaluated but its goal is to ensure "a successful continuum of care from the time a Service member is injured to the time he or she is released from military service and becomes a veteran" (Department of Defense 2013, 1).

Three major recommendations from RWTF align with this research. The first is for the Office of the Assistant Secretary of Defense for Health Affairs to develop

effective training of clinical case managers. This is a recommendation for DoD to create a method for assessing case managers' effectiveness, creating a more robust medical care case management throughout DoD (Department of Defense 2013, 10). There appears to be disparity in the information provided by the case manager to the service member and his or her family. Such a difference may be a direct result of the competencies of the case manager, but also will have a direct result of the resources the case manager provides to the family, directly impacting the veteran. The importance of case management will be reviewed in depth during the research portion of this research.

It is also recommended that the Office of the Assistant Secretary of Defense for Health Affairs should standardize the policies of PTSD psychotherapies in order to promote parity across all services and streamline care (Department of Defense 2013, 10-11). This Congressional report mentioned best practices used by the Marines and the Army. A Marine Psychological Health Pathway program and an Army Behavioral Health Data Portal were used to track patient outcomes, satisfaction, and risk factors during and after treatment. Systems such as these should be identified and used to standardize behavioral health treatment. The RWTF did mention that PTSD is culturally rooted in the military culture and must be understood among civilian providers, which may impact a transition into civilian life. PTSD also significantly impacts family members and the RWTF highly recommends that treatment approaches involve family members (Department of Defense 2013, 13). The support by families is crucial to any transition process; for families with a veteran diagnosed with PTSD (J1D 2014; F2V 2014; C3V 2014), understanding and comprehending may aid both the separation out of the military and allow both the service member and the family to cope better.

Finally, the RWTF recommended that DoD ensure TBI treatments are effective, standardized, documented, and tracked. During the site visits insufficient standardization was apparent and no TBI protocols or treatment design or documentation was used to track the efficacy of TBI treatments. Additionally, some participants identified that current TBI treatment practices were not meeting the patient's needs. The three common complaints were that TBI treatments did not meet the veterans' needs, that long wait periods for appointments were common, and that insufficient effort and poor continuity of care was given by providers. Current TBI diagnosis and treatment is still being widely researched, however it is apparent that a standard must be set for TBI treatment (Department of Defense 2013, 14).

Documentation at the national level clearly reveals the importance of Military and Veteran's mental health, which is being tracked and documented at the national level and Department of Defense. To date, all Department of Defense (DoD) mental health, suicide prevention and substance abuse programs are under review to identify the key program areas that produce the greatest quality care and positive outcomes. By the end of Fiscal Year 2014, DoD will have completed realignment of program resources as necessary to enhance the highest ranking, most effective behavioral health programs. At the Department of Defense and the VA, behavioral health continues to be addressed and action plans have been identified in order to better assist military members.

The *Army Strategic Planning Guide* (2013) mirrors the *Sustaining U.S. Global Leadership: Priorities for 21st Century Defense*, and provides a refined path forward for the Army to support the national goals. In order to accomplish supporting the national goals, support must be provided to the service men and women currently transitioning out

of the military. The *Army Strategic Planning Guide* (2013) foresees the Army's success stemming from positive compensation, sustainable benefits, and training programs that support soldiers and families (Department of the Army 2013, 17). The *Army Strategic Planning Guide* does not, however, specify current ways or means in which to accomplish these goals.

However, the *Army Strategic Planning Guide* (2013) specifically mentions two that can impact the studied populations: the Ready and Resilient Campaign and Soldiers for Life programs. The Ready and Resilient Campaign trains leaders to actively care for and provide information to services that can aid a soldier in a time of need. It also provides key resilient training concepts and techniques that a soldier can use in order to get through difficult circumstances. The Soldiers for Life program helps soldiers transition from the military to life as a civilian (Department of the Army 2013, 16). This program will come into direct use as approximately 130,000 soldiers transition out of service over the next five years, returning home to create new lives and communities. These communities become the future for sustaining an all volunteer force. Positive treatment and transition from service continues future support for the military, encouraging future generations to service (Tan 2014). Therefore, continuous effort must be given to improve the health, readiness, and resilience of the force and supporting families.

History of PTSD

Human reactions to the stressors of war and combat have been seen and felt for centuries. In the earliest epics and stories, warriors are depicted in battle suffering great loss, which then causes a change behavior such as anger, grief, or fear (Crocq 2000).

During the Civil War, common PTSD symptoms were deeded a "Soldier's Heart" or "Soldier's Melancholy" (Le Fanu 2003). Mental symptoms were hypothesized to be caused my microscopic lesions on the spine or brain, but when mental reactions turned into physical behavior, hysteria was typically diagnosed.

Around 1884, German physician, Hermann Oppenheim coined the term "traumatic neurosis" (Crocq 2000) describing common mental and physical reactions caused by traumatic railway or workplace accidents. In the 1890s Sigmund Freud proposed a theory on seduction; he later abandoned the theory, however he created a paradigm that external events cause post traumatic behavior (Wilson 1994). Abraham Kardiner, Sigmund Freud's student, expanded upon this paradigm and wrote, *Traumatic Neuroses of War* and *War Stress and Neurotic Illness*, which he made major correlations between war and traumatic events (Beall 2011; Dixon 2008). By World War I terms such as "Shell Shock" arose. In World War II and the Korean War "Battle Fatigue" and Combat Exhaustion" were added to the vernacular describing the effects of battle and war on those fighting (Grafton 1917; Hyams 2005).

The Vietnam War was a major catalyst for the psychological community studying PTSD. The size of the population and the 30-year span since the Vietnam War has allowed significant study and research on PTSD originating from Vietnam veterans. In 1983, Congress mandated the National Vietnam Veterans Readjustment Study (NVVRS). This study looked at the prevalence of PTSD and other psychological issues while readjusting to civilian life (Beall 2011). Results showed that among Vietnam vets, 30.9 percent males and 26.9 percent females had a lifetime prevalence of PTSD (Dixon 2008).

Even in 1983, Congress understood the importance of readjusting after war to civilian life.

In *Vietnam Veterans: The Road to Recovery* (1985), which studies US soldiers' reactions to returning from war and the readjustment problems that Vietnam veterans faced. The first sentence of the book, identifies the needs of veterans searching for meaning and purpose as they seek help at VA hospitals and counseling centers (1). Both the veteran and the family of the veteran expect little change upon return, but find substantial change. This idea is taken from Brende and Parson's (1986) who identifies the need to prepare both the veteran and the community for the veteran's return and transition.

> In the case of Vietnam, the veteran was not prepared to become a civilian; neither was the community prepared for his homecoming. Thus, the very vital transitional phase for an "inhuman killer" to become "rehumanized" (or "recivilianized") was neglected by the military and society. Moreover, such transition is a process; and process takes time. If Homer's Pallas Athene knew this during ancient times, what can be said of modern-day military planners, military psychologists, and society, who failed to devise and implement a useful transitional plan for Vietnam veterans? (Brende and Parson 1986, 48)

Clinically, PTSD was not formally identified and named in the *Diagnostic and Statistical Manual (DSM) of Mental Disorders* until 1980 (Dixon 2008). The *Diagnostic and Statistical Manual (DSM) of Mental Disorders* is published by the American Psychiatric Association (APA) and is used to standardize and diagnose psychiatric illnesses. The manual describes symptoms, effects, and treatment approaches. The *DSM* accounts for biological, environmental, chemical, psychosocial, and global factors affecting both the mental and behavioral states. The DSM-IV-Text Revision (TR) is the most current version of the manual used in this paper.

The *DSM* has evolved in its characterization of PTSD. Lisa Beall (2011) reviews the progression of PTSD in the *DSM* throughout history in her essay, *Post Traumatic Stress Disorder: A Bibliographic Essay*. The *DSM* was drafted in 1952 and first listed PTSD as a "stress response syndrome" falling under stress reactions. DSM-II (1968) still did not properly understand PTSD and related it to trauma related disorder, categorizing it under situational disorders. It was not until the publication of DSM-III in 1980 that PTSD was legitimized. It was labeled as a subcategory of anxiety disorders, which caused great debate over categorizing PTSD as an anxiety or dissociative disorder. Finally, in DSM-IV "the Advisory Subcommittee on PTSD was unanimous in classifying PTSD as a new stress response category" (Beall 2011, 5).

PTSD-Symptoms

Table 3 provides the DSM-IV-TR diagnostic criteria for PTSD.

Table 3. DSM-IV (TR) PTSD Criteria

Table 1. DSM-IV-TR Criteria for PTSD

Criterion A: A traumatic event in which
1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror.
Criterion B: intrusive recollection (at least 1)
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
2. Recurrent distressing dreams of the event
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated)
4. Intense psychological distress at exposure to internal or external trauma-related cues
5. Physiologic reactivity upon exposure to internal or external trauma-related cues
Criterion C: avoidant/numbing (at least 3, not present before the trauma)
1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal lifespan)
Criterion D: hyperarousal (at least 2, not present before the trauma)
1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hypervigilance
5. Exaggerated startle response
Criterion E: Duration of the disturbance (symptoms in B, C, and D) is more than one month.
Criterion F: The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

Adapted, with permission, from American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th ed., text revision. Washington, DC, American Psychiatric Association, 2000.

Source: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Washington, DC: American Psychiatric Association, 2000).

To be diagnosed with PTSD, six criterion must be met. First, a person must have experienced, witnessed, or been confronted with a traumatic event that threatens the physical self or other people with death or serious injury and then a person must respond with fear, helplessness, or horror. PTSD can occur by witnessing traumatic events of

others, which is common in war and can be experienced in several fashions by soldiers in war. The RAND study showed that "Vicariously experienced traumas (e.g. having a friend who was seriously wounded or killed) were the most frequently reported" (Tanielian and Jaycox 2008, 96).

The DSM-V was released May 2013, and was not used for this research. It is important to note that there are significant changes to Criterion A, which no longer requires horror or emotional distress at the time of the event. This is important because a soldier is trained to not respond with distress in the moment. DoD is the mandatory standard until the DSM-V is implemented October 2014 with the International Classification of Diseases (ICD) version10.

The second criterion is the intrusion of recollected events of the past trauma. Recollected events include events, images, thoughts, perceptions, or dreams, which reoccur and intrude upon daily life. This intrusion may lead the service member to react physically, cause a physiologic reaction, or cause psychological distress.

The third criterion is categorized under avoiding and numbing. A person will put effort into avoiding thoughts, feelings, locations, people, places, or conversations. A person will detach from others or restrict their internal feeling. For example a husband recently returned from combat may not make an effort to connect to his wife or children and may feel lack of love. Symptoms can also be combined with a diminished interest in life activities and a lack of desire to participate in life. The third criterion is often associated with alcohol and substance abuse in order to help with the numbing, avoiding, and distancing of self (Taylor 2006, 17).

The fourth criterion is Hyper-arousal, which is commonly exhibited in sleep, concentration, hyper-vigilance, over-exaggerated startle response, and anger. Hyper-vigilance is when a person is on constant alert to one's surroundings, evaluating every person or situation as a possible threat or issue to deal with. In war, hyper-vigilance can save lives because it takes high concentration and high alert which, keeps the body at a ready-state at all times. This ready-state is physically and emotionally draining.

The duration of all criteria must last one month or longer and the symptoms must causes significant social, occupational, and functional distress for PTSD to be diagnosed. The severity of PTSD is categorized into Acute, Chronic, and Delayed Onset. Acute PTSD is when symptoms lasts one to three months. Chronic PTSD lasts longer than three months and it is estimated that 30 percent of combat veterans diagnosed with PTSD have Chronic PTSD (McAtamney 2007). With Chronic PTSD, evidence shows that when a Soldier is unable to adapt, deal with, or treat the symptoms, these problems may remain chronic for life (Prigerson, Maciejewski, and Rosenheck 2001). PTSD may not emerge for months, years, or sometimes even decades (Taylor 2006). Delayed Onset PTSD where the delay of symptoms is not present for at least six months, exhibiting symptoms for a period lasting longer than six months. Delayed Onset PTSD, if left untreated, makes treatment less effective because PTSD symptoms and a soldier's reaction to symptoms become ingrained (O'Dell 2007).

Post Traumatic Stress Disorder is often comorbid with other psychiatric disorders, which often may overshadow PTSD. Comorbidity is a simultaneous presence of symptoms or disorders; in the case of PTSD, additional anxiety, mood, and or substance abuse disorders commonly occur with PTSD (Taylor 2006, 17). "Breslau et al. (1991)

found that 83% of people with PTSD also had at least one other disorder, most commonly substance abuse or dependence (43%), major depression (37%), or agoraphobia (22%)" (Taylor 2006, 17). These more outwardly expressed disorders maybe noticed in a soldier prior to identifing PTSD. For instance, a soldier is re-experiencing a battle where he lost and saw his friend die. The soldier returns home and begins to drink in order to forget, or numb, the recollected trauma. The over drinking (substance dependence) is noticed first by his wife, then by the soldier's supervisor. The supervisor sees the drinking as the issue and may not be aware of the underlying cause.

Studies have shown that multiple traumas and cumulative exposure to traumas increase the risk of PTSD (Taylor 2006, 11). By the end of 2010, 2.15 million members had been deployed an average of 1.7 times: 27 percent (580,500 people) had deployed twice, 10 percent (215,000 people) had deployed 10 percent and 6 percent (129,000 people) had deployed four or more times (IOM 2013, 46). Bremnar (2002) adds validity by examining how stress works on the biological and chemical aspects of the brain and identifies that repeated stress may irreparability damage the natural stress response system; affecting how soldiers adapt to new stressors. Upon return from combat (trauma) the soldier and the soldier's body is not able to recover, increasing the chance and symptoms of PTSD. The Mental Health Advisory Team IV showed a 10 percent increase in positive screening for mental health issues between soldiers and marines returning from multiple deployments (two to four) versus single tour soldiers and marines (Kennedy 2007), continuing to support that multiple traumas create an increased risk to PTSD.

Post Traumatic Stress Disorder symptoms often have common TBI symptoms such as headaches, irritability, memory issues, fatigue anxiety, and depression (Lawhorne and Philpott 2010). PTSD or PTSD symptoms are often present after a TBI; however, the overlap of both dignosees can complicate the assessment and the rehabilitation. Therefore both PTSD and TBI must be fully understood.

Traumatic Brain Injury

The most common combat injury in combat, seen in both Iraq and Afghanistan, is associated with missile warfare and explosions and blasts from RPGs and IEDs (Lawhorne and Philpott 2010). Blast exposure can cause multiple level injuries resulting in impairments to organs, bodily systems, and brain functioning. “A “blast injury” refers to injury from barotraumas caused by either an over-pressurization or under-pressurization of air over normal atmospheric pressure that affects the body’s surface due to exposure to detonated devices of weapons” (Lawhorne and Philpott 2010, 20). It is the blast wave that has a great affect on air and fluid filled organs causing common injuries such as middle ear damage, abdominal hemorrhage, pulmonary barotraumas, bleeding (tare) in the globe of the eye, and concussions (SITE).

Identifing an IED as a traumatic event is accuate and relevent because one blast causes more physical damage at four different levels, in addition to the emotional damage that follows. One blast has four main components, each component carrying risk and injury. The primary blast is from the blast itself and exposes an overprssurization at a high velocity affecting the invironment. It is the primary blast that affects air and fluid filled organs. The secondary blast is the result from the primary blast and includes debris and fragments flying through the air, causing additional risk and injury. The tertiary blast

is when a person is thrown from the blast. A person is ejected through the air usually colliding with other flying matter or landing on fixed locations such as a wall, or steering wheel. Finally the quaternary blast causes other injuries from the blast such as burns, crashes, or fumes from the blast. Understanding each component shows the complexity of a TBI.

A concussion is a TBI without a physical head injury (Lawhorne and Philpott 2010, 23). Originally mild head injuries were believed to be easily recoverable; however, a small percentage of mild head injuries took longer to recover post injury. In the mid 1980's the University of Virginia studied concussions and mTBI in sports. Results showed that injury to the head caused neurocognitive deficits in attention, memory, and processing ability (Lawhorne and Philpott 2010, 23). Similar symptoms are seen in Iraq and Afghanistan after IED blasts. Advancement in technology and protective gear for soldiers reduces the effect of the blast, however mild to moderate TBIs are extremely prevalent (Lawhorne and Philpott 2010, 24).

The DoD and VA share a common definition of TBI as:

> A traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event:
>
> Any period of loss of or a decreased level of consciousness;
>
> Any loss of memory for events immediately before or after the injury;
>
> Any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.);
>
> Neurological deficits (weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia, etc.) that may or may not be transient;
>
> Intracranial lesion. (CDC 2008)

Traumatic Brain Injury has a scale of severity ranging from mild, moderate, severe, and penetrating. A mTBI is defined as a loss of consciousness for less than 30 minutes, a confused state or memory loss for less than 24 hours, and normal structural brain imaging by an MRI or CT Scan. Moderate TBI is characterized by a confused state lasting more than 24 hours, a loss of consciousness for more than 30 minutes and less than 24 hours, memory loss more than 24 hours but less than seven days, and normal or abnormal structural brain imaging. Severe TBI increases a loss of consciousness for more than 24 hours and memory loss to more than seven days to the Moderate standard. Finally, Penetrating TBI is an open head injury in which the outer layer is penetrated (Lawhorne and Philpott 2010, 36).

Diagnosing TBI can be difficult. A blast related injury may occur simultaneously with other life threatening injuries and a TBI may not be identified in closed brain injuries because there are not outward signs of physical trauma. Risk also increases with multiple, cumulative, or repetitive concussions or TBIs. The likelihood increases three fold once a TBI has been sustained (Lawhorne and Philpott 2010, 25). Most TBI is mild and takes one to three months to fully recover, however symptoms for veterans are extended for up to 24 months after the injury, which is 18 months more than the civilian experiencing a mTBI (Lawhorne and Philpott 2010, 33, 37). Include the comobridity of PTSD, and symptoms and neurological and cognitive symptoms are often dismissed by soldiers. Symptoms such as reduced reaction time, issues in making decisions, reduction in memory and concentration, sadness, nervousness, and depression may not be acknowledged and therefore, not properly diagnosed or treated (Lawhorne and Philpott 2010, 33-34).

The Defense and Veterans Brain Injury Center (DVBIC) studies, assesses, and treats closed brain injuries during combat. A DVBIC accounts for 280,734 known cases of TBI, but RAND (2008) also estimates that about "57% of the affected population have not been evaluated for a brain injury by a physician" (Tanielian and Jaycox 2008, xxi). TBI could account for up to 50 percent of combat-related casualties, although actual hard numbers are difficult to find. Soldiers who suffer from battle injuries such as TBI's have higher rates of PTSD and other behavioral health conditions (MacGregor et al. 2009). "Patients with TBI often meet criteria for PTSD on screening instruments for TBI and vice versa. Some of these positive screens may represent false positives, but many OEF/OIF veterans have experienced a mTBI and also have PTSD related to their combat experience" (Lawhorne and Philpott 2010, 38-39). Advances in treatment, surgery, and evacuation increase the survival rate of many soldiers, however it also increases the population of injured soldiers leaving a long road to recovery (Lawhorne and Philpott 2010, ix).

Integrated Disability Evaluation System

Diagnosing TBI and PTSD poses difficulties, however diagnostic standard have been set in order to assist. Neither condition of TBI or PTSD, together or separate, make a soldier unfit for service, an effective disability evaluation system is essential to fully and properly evaluate a soldier to determine a return to service or a transition to civilian life (Mortimer 2013, 35).

The Integrated Disability Evaluation System (IDES) documents the medical conditions that impact military members and their ability to function within the military or within the civilian sector. It provides wounded and injured service members a

consistent, timely, and equitable treatment process through their transition to veteran status (Department of Defense Office of Warrior Care Policy 2013). IDES aims to create and utilize a single set of physical and behavioral health medical examination and disability ratings to meet the needs of both the VA and the DoD.

The IDES is an update to the Disability Evaluation System (DES) and was fully implemented into the Army September 30, 2011 (Mortimer 2013, 53). Managed by the DoD Health Affairs, Office of Warrior Care, IDES is a joint program between the Department of Veterans Affairs (VA) and the Department of Defense (DoD). IDES consists of four phases: Medical Evaluation Board (MEB), Physical Evaluation Board (PEB), and a Transition Phase, and a Veteran's Affairs Benefits phase. This thesis will only cover the major aspects of the IDES process to provide an overview.

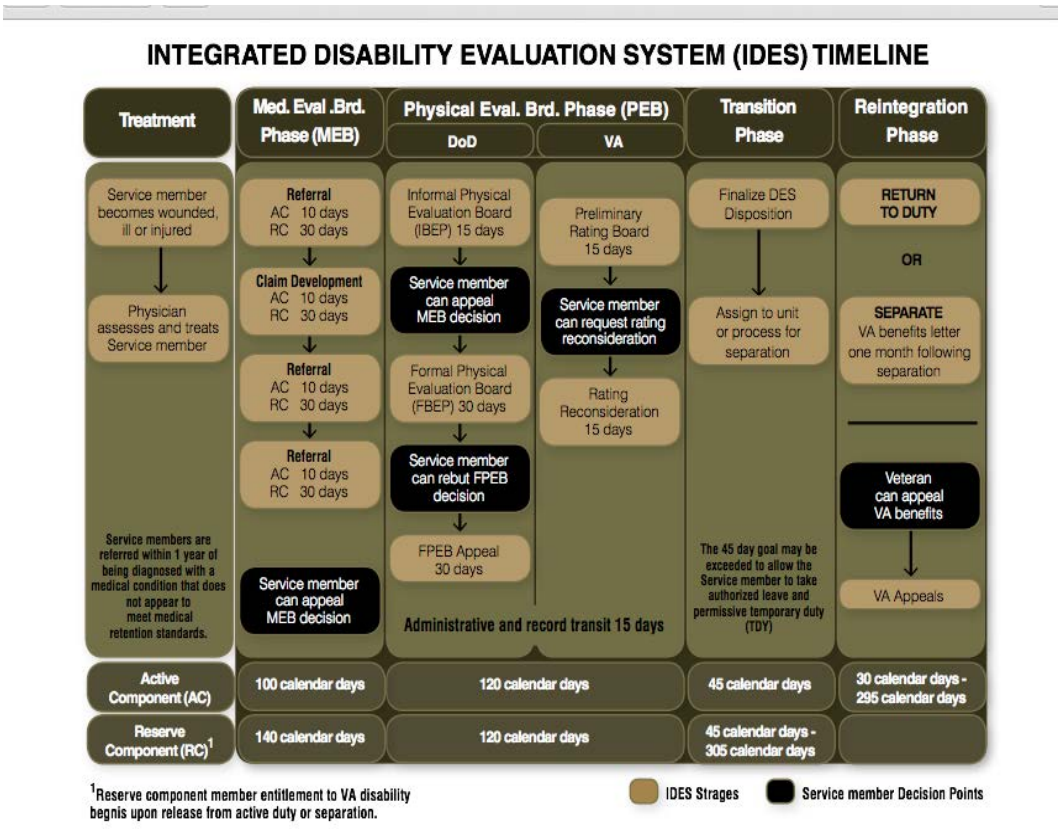


Figure 1. Integrated Disability Evaluation System Process

Source: Government Accountability Office, *Military Disability System: Improved Monitoring Needed to Better Track and Manage Performance* (Washington, DC: Government Printing Office, 2012), 5.

The IDES was created to streamline the evaluation process and reduce the soldiers' processing time, from the initial medical profile to final release from active duty status (figure 1). This four phase process begins with Phase 0: Treatment. The treatment phase occurs when the medical provider issues a Soldier a temporary profile for a medical conditions causing limitations in the Soldier's ability to perform his or her duty. A temporary profile will not be continued past a year, unless approved by the MTF Commander of designated Physician Profiling Authority (PPA). A temporary profile that

continues to be an issue must be evaluated to determine if the medical condition prevents a Soldier from meeting retention standards. A Medical Retention Determination Point (MRDP) is the point in treatment where nothing more can be done to assist a soldier in recovery, and is the decision point to refer a soldier to a Medical Evaluation Board (MEB). MRDP Definition:

> A Service member with one or more conditions failing to meet medical retention standards will be referred into IDES by competent medical authority at the point of stabilized, the course of further recovery is relatively predictable, and where it can be reasonably determined that further treatment will not cause the member to meet medical retention standards or render them capable of performing the duties required by their office, grade, rank, or rating. (Coley 2011)

The MRDP will be made within one year of being diagnosed with a medical condition that does not appear to meet medical retention standards or if it is determined that the member will not be capable of returning to duty within a year (Coley 2011).

A Liaison Officer is assigned to assist the Soldier through the confusing and overwhelming process and is titled the Physical Evaluation Board Liaison Officer (PEBLO). The PEBLO is the central figure and the link between the Soldier, the medical community, the legal community, and the administrative community during this process.

Phase 1 is the MEB and it has three stages. The first stage begins with the Referral Stage, where the soldier is in-processed into IDES and a case file is created to track the soldier and his or her evaluation. The VA and DoD track the entire process The PEBLO is responsible for contacting the Soldier to schedule an introduction/orientation meeting in which to review the claim, assist the Soldier through the process, and answer any questions the Soldier may have. The Soldier must also receive a legal brief reviewing rights and responsibilities during the IDES process. Legal counsel is always made available and provided as the Soldier may need.

There is shared responsibility between the Chain of Command, the Soldier, and the PEBLO. The chain of command provides input to whether medical issues impact or impairs the soldier's ability to perform his or her duties. The chain of command and the Soldier is thus responsible making all scheduled appointments and coordinating approved leave with the PEBLO to prevent delays in processing. The triad relationship is critical and is identified as a Transition concern by the interviews conducted. This will be further discussed in chapter 3 and 4.

The Claim Development Stage reviews the IDES disability rating process and the VA's responsibilities. Compensation will only be awarded for chronic illnesses, injuries, and diseases that were obtained or agitated while in service. Claims made after the initial interview may not be evaluated until after separation and it is therefore important to make all claims up front. This poses an issue because PTDS has been documented to have a delayed response, not showing effects until months or years after the trauma has occurred.

The Medical Evaluation Board is the next stage and is an informal process to determine if medical issues restrict a Soldier from performing his or her military duties in accordance with the Army Regulation (AR) 40-501. All general and specified exams occur to include vision, hearing, psychological conditions, or other complex medical conditions. A MEB provider reviews all the documented medical data from the Compensation and Pension exam and composes a Narrative Summary (NARSUM) of all medical issues.

The NARSUM is critical and addresses all claimed conditions and makes determinations about the impact of each condition. Behavioral health providers may

prepare NARSUMs when there are significant questions within the behavioral health realm. Additionally, Behavioral health providers are required to review when behavior health issues are listed and apart of the claim.

The board is then conducted by two credentialed medical providers and an Approval Authority who review the NARSUM and the MEB case file and determine if a Soldier Returns to Duty (RTD) or if he or she must undergo a Physical Evaluation Board (PEB). The Soldier has the legal rights to get an Impartial Medical Review (IMR), who is usually the medical provider most familiar with the Soldier's case, who can review the medical file for accuracy and completeness. The Soldier can also appeal the MEB findings and rebut the determination, which will trigger an outside, objective senior medical physician to review and decide to uphold, amend, or return the MEB for reconsideration.

The PEB Phase is next phase and consists of the informal and formal Physical Evaluation Board, once it is determined that a soldier does not meet retention standards. The Informal PEB stage determines a Soldier's fitness for continued service and request a preliminary VA disability rating with supporting rationale. The Soldier, with aid from the PEBLO and legal, will then accept or not accept the VA rating and PEB findings. Any Soldier designated unfit for duty may request a Formal PEB and has only one chance to request reconsideration for each rating for his or her medical condition. At the conclusion, after all appeals are made, any new claims or disagreements will be addressed after the Soldier is separated from service. Future claims add additional personal and financial stress on a soldier. If PTSD is already identified, than the stress of having to file a new claim may be overwhelming. If PTSD is not diagnosed but is

triggered after release from the military, as was the case for Gonzalez-Prats, than "PTSD impact[s] every part of life, personal, academic, and professional" (2008, 3). Time is needed to both comprehend and seek treatment for the PTSD. The financial stress will be discussed within the Transition Process Concerns section of this thesis.

The final phases are the Transition Phase, 45 days, and the Reintegration or separation stage, 30 days, which allow a Soldier to out-process, retire and or separate from the Army. The Installation Transition Center and chain of command work with the Soldier in order to assist in the final transition. Final separation must occur within 90 days and a Certificate of Release or Discharge will be given. Upon release a final rating from VA will be given concerning final benefits and ratings for the Soldier's claim.

The entire process is estimated to take 295 days from start to finish (figure 1). Although the current aim is to processes service members through IDES in 295 days, the goal is subject to several variables, including processing time of supporting documentation, medical needs of the patient, and command support, all of which may hinder or delay timely processing. The transition process for a MEB/PEB patient is different from a non medical transition. It is during the MEB and the PEB that the soldier may begin to undergo a transition-like process in order to prepare for a possible future outside of the military. The IDES section solely reviews the evaluation board process. During the board process, preparation through completion, the service member is allotted time to plan and prepare for transition into civilian life, including education and certifications for their future (Department of Defense Office of Warrior Care Policy 2014).

Transition Process

The specific IDES Transition and separation phase is projected at 75 days, however the transition process itself begins well before the Transition phase, and is started rarely in the IDES process. In 2002, Congress identified the importance of providing proper time for transitioning out of the Army and mandated: "In the case of a separation other than a retirement, pre-separation counseling shall commence as soon as possible during the 12 month period preceding the anticipated date" and "no event shall pre-separation counseling commence later than 90 days before the date of discharge or release" (Congressional Mandate Chapter 58, Title 10). Transition is mandated to begin no later than 90 days before separation; therefore, the 45 day Transition phase of IDES does not meet the 90 day qualification, which is why the transition process begins earlier at the MEB.

There was no specific concurrent documentation, rules, or regulations found which guides the transition process with the IDES process. The Pre-separation Counseling Checklist, Form DD2648 and DD 2648-1, which is a mandatory part of the MEB packet. Having the checklist as a mandatory part of the MEB packet, and infers that a soldier has initiated a process for transition or separation from Army service. This checklist appears to be a link between the MEB and the Army Career and Alumni Program (ACAP) Transition Process.

At Fort Leavenworth, Phase I of the MEB includes in-processing the ACAP, which is the U. S. Army's comprehensive job assistance and transition program. In 1990, Congress directed the military to establish a program to assist in job transition after military downsizing from Operation Desert Storm (Gonzalez-Prats 2008, 8). The DoD

answer was the Transition Assistance Program (TAP), which focused on providing employment assistance upon completion of military service (retirement or separation) and assisted with the transition into civilian life. The Army followed DoD's guidance and TAP initiative and created ACAP in 1990. The ACAP program was well received and widely praised at test pilot sites that by 1998 ACAP was successfully operational at 45 locations (Directorate of Human Resources, U.S. Army Garrison, Fort Knox, Kentucky 2014; Army Career and Alumni Program 2014a).

The ACAP provides personal assessment to tailor the transition process for each individual. It presents briefings and provides information on all services and resources available within ACAP and includes the following information on transition: (1) employment, (2) relocation, (3) education and training, (4) health and life insurance, (5) finances, (6) reserve affiliation, (7) disabled Veterans, and (8) retirement" (Department of the Army 2014a). ACAP's pre-separation information is so critical to the service member that it is mandatory in order to be released from the service (Army Career and Alumni Program 2014b).

The mandatory Pre-counseling checklist, referenced as Appendix B, provides an a la carte menu within the aforementioned services and resources provided by ACAP for the soldier and accompanying family members to attend. An initial ACAP counseling session allows each soldier to meet with an ACAP counselor to review future, personal goals and talk through the transition process (ACAP chief). The ACAP counselor and soldier will create a tailored transition plan, to include all corresponding briefs and resources that will start the soldier on a path to a hopeful successful transition. It is this

initial session that initiates a soldier into the ACAP process and creates a transition basis on which to build.

The ACAP and TAP have a strong focus on employment and assisting in creating a smooth transition into civilian employment. Under the subset of employment and employment assistance, information is given to help soldiers find new employment upon separation. Information is provided on unemployment, federal, state and apprenticeship employment opportunities; and classes are given on resume writing and interview techniques. This information is critical for veterans because the 2014 unemployment rate for veterans continues to outpace that of the rest of the country (Watson 2014).

In 2010, the unemployment rate for American veterans was 12.1 percent of the Iraq and Afghanistan veterans, compared to 8.7 percent of non veterans (Department of Labor 2011). In 2011, President Obama signed The Veterans Opportunity to Work (VOW) to Hire Heroes Act in order to reduce the unemployment rate amongst veterans. The VOW to Hire Heroes Act combines Veterans Opportunity to Work (VOW) Act, Hiring Heroes Act, and veterans' tax credits. The plan provides: an additional year of education benefits for high-demand sectors; TAP improvement and regulations; ease of transition to civil service by starting the federal process prior to separation; encourages the Department of Labor to translate military skill set and training into civilian jobs; and provides tax credit for hiring veterans and disabled veterans (House Committee on Veterans Affairs 2014). Currently in 2014, unemployment rates have declined to 6.8 percent from the high of 12.1 percent (Department of Labor 2011), however the transition to find new employment is a major aspect to the transition process and greatly affects the financial support and stability.

The ACAP program also offers financial training, relocation information, and disabled veteran information, all three linking to financial support. Timely financial support is a major component to transitioning and one that causes a great deal of stress (Briggs 2013). ACAP provides financial management classes such as budgeting and debt reduction, and reviews separation pay and unemployment compensation. Additionally, there may be a relocation allowance allotted, to assist with completing a final move. Finally, there is a full brief available to review the Disabled Veterans Benefits.

The VA Benefits Brief I and II are aimed at soldiers referred to a PEB and those who have a service connected disability. The VA Benefits Briefings offers personalized vocational rehabilitation and employment assistance. It reviews insurance, specially adapted housing, and the Americans with Disabilities Act, the GI Bills, VA home loans, and other service-related benefits and provides online VA training to teach and instruct how to navigate the online system (Department of the Army 2014b). This brief becomes critical for a soldier completing IDES and being separated from the Army. It reviews timelines and benefits, which directly affect and impact possible income that the soldier may need in order to sustain.

The Pre-counseling checklist will then be used to develop an Individual Transition Plan (ITP), as referenced in Appendix C. The ITP is used both with the PEBLO and with ACAP provides a framework to set future goals based upon skills, experience, and abilities on which to rely. The ITP allows the soldier to identify actions needed to assist with the transition and keep the activities organized and manageable. The soldier will identify employment, education, training, and future goals and milestones in which to get to the desired transitional end. This is a comprehensive concept when used

properly and applied to the transition process. The transition and separation process has been identified as an important and crucial part of the military experience.

The Veterans Affairs Health Care is the nation's largest integrated healthcare system with more than 200,000 employees providing coverage to over 8 million total enrollees. But with almost 1,000 medical facilities across the country (Siegel 2014). The transition from DoD to the VA is the focused area of this thesis. The transfer of care for soldiers with PTSD and mTBI is critical during the transition process. The care the government provides for men and woman who served the country is reflective of the respect for the profession and sacrifice of those who serve.

President Roosevelt understood the importance of transitioning out of the military and back into civilian life. He saw veterans from World War I return to poverty and unemployment and in 1944, President Roosevelt enacted The Servicemen's Readjustment Act of 1944, which provided comprehensive support for over the 16 million returning WWII veterans (Greenberg 1997, 10). More recently, from 2002 to 2011, nearly 1.2 million out of 2.1 million service members have separated from the active duty military. Approximately 400,000 of those separated from service were diagnosed by the VA with a mental health disorder, the most prominent cases being members suffering from PTSD and depression (Tanielian and Jaycox 2008). For the over 130,000 plus service members being released from service and the future soldiers to be separated through the IDES process, it is crucial to provide a complete, thorough, and efficient system on which to transition out of the military.

Chapter 2 examined National documentation, which supports the government's involvement and directives that dictate the need to provide proper care and aid to service

members, veterans, and families. The history and background of PTSD and mTBI provided a medical reference to frame the challenges that face the population. The IDES, ACAP, and separation process is needed to fully understand the scope and process of separation that a soldier with PTSD and or mTBI faces upon separating the Army through the IDES system. The entire process must be understood in order to fully understand how the transition process occurs from DoD Army to the VA and civilian life. Chapter 3 will describe the methodology on which the research was conducted and Chapter 4 and 5 will provide the results of the study and the conclusion drawn.

CHAPTER 3

RESEARCH METHODOLOGY

The purpose of this research was to study the active duty transition process for soldiers diagnosed with PTSD and mTBI, after completing a MEB and PEB. This thesis also aimed to identify trends within the transition process that both impedes and assists soldiers from making a successful transition into civilian life. The methodology and rational to use a document review and interview methodology for collecting information and research are described in this chapter. This study uses qualitative research methods: reviewing and presenting documents, current policy, and procedures, and conducting interviews with key personnel who assist with the separation transition process for soldiers.

The primary research question is, "What factors facilitate positive behavioral health and a successful transition into civilian life for Soldiers undergoing a medical and physical evaluation board diagnosed with mild Traumatic Brain Injury and Post Traumatic Stress Disorder separating from active duty service?" To answer this question the following secondary questions are of vital importance:

1. What is the existing process for members separated for behavioral (PTSD and mTBI) health issues?
2. What are Case Managers' (Army and VA) responsibilities and actions that facilitate a successful transition?
3. What soldiers' and veterans' actions facilitate a successful transition?
4. What are common trends and or issues that improve or impede behavioral health healing for Soldiers?

5. What actions by the Behavioral Health Providers facilitate a successful transition?

Research Design

Qualitative research for this study was used as it allows both document review and in depth interviews. Research and document review supplements interviews with additional supporting information, and is unobtrusive and rich in value (Marshall and Rossman 2006, 107). The in-depth interview as provided by A. N. Oppenheim states "Probably no other skill is as important to the survey research worker as the ability to conduct good interviews" (1996, 65). The purpose of an in-depth interview is to gather ideas and research the intended thesis, rather than to gather facts and statistics (Oppenheim 1996, 67). The intent of this research design was to gain internal information and insight from trained professionals on the trends observed during separation transition.

Document Review

Historical context and background data is critical in qualitative research study. The information presented provides context surrounding symptoms and diagnosis of PTSD and mTBI, procedures of the IDES medical process, and the separation transition process. The base information provides a beginning start point on which to build in order to answer the primary research question. Marshall and Rossman (2006) formulated and presented this concept of historical, context, and document review. The data collected was then processed and the content was analyzed in order to provided quantitative information and supporting statistics and percentages that on the main topics of this thesis (Marshall and Rossman 2006, 108). Research and document review was conducted to

obtain a complete understanding of the issues that impact the separation and transition process for soldiers diagnosed with PTSD and or mTBI completing a medical board. The document review was selected to answer the first secondary question, which asked, "What is the existing process for members separated for behavioral health issues (PTSD and mTBI)? This question identified issues in the transition process that will be discussed in chapter 4 and 5 of this research.

Interviews

In-depth interviews (Appendices F, G, H, and I) were conducted in order to provide professional insight to the transition process. The transition from active duty Army to VA through the IDES process is not guided by Army or DoD regulation and has no regulated, parallel process to IDES. Interviews were conducted with a local IDES PEBLO, a local and a distant VA case managers, and a distant veteran who separated out of the Army and into the VA system. The local contacts were interviewed in person and both distant contacts were interviewed via phone. In-depth interviews in this research do not properly represent a survey population size. By the very nature of the exploratory interview, interviewing a large population takes dedicated time, which was not available for this thesis (Oppenheim 1996, 67). However, the in-depth interview allows the participants views to be highlighted because they present valuable information and are able to produce data in large quantities and in a timely manner (Marshall and Rossman 2006, 101). All interviewees were considered "elite" and selected due to expertise in the transition process (Marshall and Rossman 2006, 105).

There are challenges inherent to qualitative interviews. Cooperation is essential and interviewees may be unwilling to be interviewed. This research was originally

intended to interview both a VA and a DoD case manager. Due to scheduling issues the DoD case manager could not be scheduled for an interview. The impact of not interviewing a DoD case manager will be further discussed in chapter four and chapter 5 of this thesis.

The interviews were transcribed and processed. Transcription of interviews into coherent, understandable written word supporting a thesis can be difficult (Marshall and Rossman 2006, 110). Interviews were recorded to assist with recollection and validity of interviewee information. Interview results were then compared in order to identify matching themes and recurring ideas that link back to the original research question. This inductive analysis allowed transition trends to emerge from the interviews and interpretation to be applied to the trends. Interviews answered the second, third, and forth secondary question and allowed analysis to be applied in order to surmise impacting trends during the transition process.

Protection of Human Rights

This research is exempt from human subject review. Due to the sensitive nature of this research, personally identifying information was not used for the interviews, names were omitted and identifying markers per each interviewee was assigned. The Command General Staff College (CGSC) Quality Assurance Office provided oversight of the case study and interview questions. The research in support of this thesis was voluntary in nature. Participants were provided a written and verbal brief of the Informed Consent, referenced as Appendix D, and all participants were informed how to request a copy of the final research product.

Summary

Chapter 3 provided the research question, the proposed methodology and supporting rational for the design of this research. For the reasons discussed, a qualitative study that included document review and interviews in order to find transition trends was selected. This chapter described the importance and disadvantages of both document review and interviews. It addressed mitigation strategies to overcome possible disadvantages and provided links from the methodology to the research questions. Chapter 4 provides the results from the interviews in a coherent and themed manner.

CHAPTER 4

ANALYSIS

Introduction

This research examined the transition process of soldiers separating out of the Army, specifically soldiers completing the IDES process, diagnosed with PTSD and or mTBI. The President, Congress, the Secretary of Defense, and military leadership have deliberately addressed the importance of the health, welfare, and well-being of military members and veterans. Historic and context research was conducted to explain PTSD, TBI, the IDES process, ACAP, and the transition process of DoD and VA. Interviews were conducted to ascertain the process of transition from a PEBLO, two primary VA case managers, and a current veteran diagnosed with PTSD. Interviews explored the administrative and personnel handover process from DoD to VA and the associated challenges. Additionally, this research explored positive and negative process trends and revealed the criticality in a positive transition process for the betterment of the veteran's long-term transition success.

Research Question

The primary research question is, "What factors facilitate positive behavioral health and a successful transition into civilian life for Soldiers undergoing a medical and physical evaluation board diagnosed with mild Traumatic Brain Injury and Post Traumatic Stress Disorder separating from active duty service?" To answer this question the following secondary questions are of vital importance:

1. What is the existing process for members separated for behavioral (PTSD and mTBI) health issues?
2. What are Case Managers' (Army and VA) responsibilities and actions that facilitate a successful transition?
3. What soldiers' and veterans' actions facilitate a successful transition?
4. What are common trends and or issues that improve or impede behavioral health healing for Soldiers?
5. What actions by the Behavioral Health Providers facilitate a successful transition?

Interviews

Interviews conducted had four major topic areas: the process, the trends, the impact on the soldier and veteran, and the implications to PTSD and TBI. The first topic allowed the interviewee to relate the transition process as understood and executed by the interviewee. The second topic identified both positive and negative aspects of the process as understood and executed by the interviewee. The third topic addressed transition impacts and affects on soldiers and veterans that have been observed by the interviewee, and the final topic related back to the behavioral health related issues of PTSD and mTBI.

The interview processes allowed open communication in an free-style interview to encouraged spontaneity and continuous monologue by the respondent, which resulted in "idea collection" (Marshall and Rossman 2006, 67). Results from interviews allowed the secondary questions of this thesis to be addressed. Secondary questions were focused to find an answer to the primary research question.

Questions

What is the Current Process upon Exiting from the Army that Soldiers "Should" Execute to Continue Treatment for Documented Injuries?

It is important to identify, that upon completion of Active Duty status and upon official release authorized by DoD, the individual is no longer an official soldier. This is not to discuss, nor demean, the status of that individual, rather to identify the individual as a citizen who is no longer dictated by DoD regulations or standards. Identifying personal responsibility is key to understand that the individual and former soldier has complete rights of refusal of service, non-compliance, and non-cooperation. This important fact may appear obvious, however the reminder from F2V (2014) reiterated that a separated individual is no longer bound by military or VA regulations and can choose or refuse to conduct a designated transition process. This implies personal responsibility that a transitioning individual must make within the transition process itself.

The IDES is one method that separates soldiers out of service. IDES attempts to integrate the ACAP process in order to address the pre, final, and post stages of the separation process; however, no deliberate integration policy or regulation is apparent. Additionally, as identified by J1D (2014), each case is unique and each situation must be tailored to the soldier. Individual circumstances provide a great deal of variance even if physical and behavioral medical conditions are similar.

All three case managers narrated scenarios that described variables which affected separation. Variable consisted of administrative paperwork, processing time for administrative paperwork, IDES documentation from either MEB or PEB into the database system, command support, and timelines (J1D 2014; F2V 2014; C3V 2014).

IDES clearly identifies mandatory paperwork that must be completed for every soldier, however external situations may delay the timeliness of producing the required documentation and delay the processing timeline, which impacts the soldier's separation and timeline for separation. J1D (2014) gave a specific example and recalled a moment when the sole, DoD separation orders point of contact was sick, which then created a backlog of orders to be completed in mass. Upon the order's clerk recovery, influxes of orders were drafted and soldiers had minimal time to react. This unforeseen variable created changes in the separation process unique to that group of soldiers.

Coordination between DoD and VA assists in the process to transition an individual into the VA system. This coordination can be completed by telephone or email by a DoD representative or VA Liaison (LNO) embedded within the DoD IDES process (F2V 2014). The VA LNO is not at every installation; however C3V (2014) absolutely identifies that cases with a VA LNO increases communication and improves the hand over between DoD and VA. The VA LNO contacts the regional VA that will provide services to the veteran and informs the regional VA of the inbound veteran. The regional VA will confirm receipt of the information and has seven days to make initial contact with the veteran (F2V 2014).

Initial contact with the case manager will confirm or initiate enrollment into the VA health care system and will schedule the new enrollee for a new patient primary care appointment. The timeliness in which initial contact with the soldier is made varies widely (J1D 2014; F2V 2014; C3V 2014). Initial contact can be made while the soldier is still processing through IDES, upon issue of separation orders by DoD, or within the

soldier's terminal leave period (F2V 2014), which is directly connected to the communication and coordination between DoD and VA.

Both VA case managers identified that the initial appointment with a primary care provider is the foundation from which all other appointment can be made. This is a mandatory step. Referrals to other clinics such as behavioral health, physical therapy, and neurology can only be made upon completion of the initial visit with a primary care provider (F2V 2014; C3V 2014). If initial contact with the soldier is during the IDES process then the ability to schedule an initial appointment immediately after final discharge is more likely and will reduce the wait time. If contact cannot be made with the veteran then the wait time to schedule an appointment will increase (F2V 2014). Long wait times can negatively impact treatment of behavioral health concerns and will be discussed in the following two questions sub-sections.

Emergency care is available, which can offer relatively immediate services in order to supplement physical and behavioral care (F2V 2014). As described by F2V (2014) emergency care can be used in order to fill PTSD medications that are running out. It provides a quick solution while waiting for an initial appointment with a primary care provider. The emergency care option can provide much needed immediate care, however does not solve the systemic issues of long wait times.

Finally, follow up, specialty, and all associated appointments can be made upon completion of the initial primary care provider appointment to support the veteran (F2V 2014; C3V 2014). The Behavioral Health specialty clinic can be scheduled for follow on treatment and services which provide a multitude of therapy options for veterans with PTSD and mTBI. Neurology can be scheduled to continue to address mTBI issues.

Reiterated from chapter two, mTBI is mild and takes one to three months to fully recover but symptoms for veterans may extended for 24 months after the injury (Lawhorne and Philpott 2010, 33, 37). mTBI is usually addressed and or treated while going through IDES, however TBI screenings are conducted during the initial primary care appointment or with the case manager, if the mTBI is residual or the damage is cumulative (F2V 2014). mTBI has overlapping symptoms with PTSD, and after recovery from the mTBI, the PTSD may still need to be addressed in follow up appointments with behavioral health (F2V 2014). Upon completion of the initial primary care appointment, the veteran is transitioned into the VA system and has officially become vested. One annual appointment must be maintained to keep VA veteran status current.

Upon Release from Service, What are the Major Aspects of the Transition Process that have the Greatest Impact to Help a Veteran?

The VA case manager is a central figure that can provide a wide range of assistance to the veteran. By guidelines (Appendix E), the role of the case manager is to:

> [A]ssists OEF/OIF/OND service members and veterans in coping with acute illness, chronic illness, combat stress, residuals of traumatic brain injury (TBI), community adjustment, addictions, and other health and mental health problems. The incumbent social worker case manager addresses home care needs, homelessness, and transition across levels and sites of care. (Roles and Responsibilities 2014)

This broad definition summarizes the wide range of responsibilities of a case manager, but does not capture the relational importance of the case manager. The case manager builds rapport with the veteran, learning the veteran's needs and future plans, which allows the case manager to tailor the proper assistance and services to help the veteran. The case manager tracks the veteran's treatment plan and is able to act on behalf of the veteran to provide referrals or recommendations to other clinics and services.

Additionally, the case manager is able to link the veteran to external resources that may be needed to support the veteran, the veteran's family, and assist in social functioning.

One of the most impactful aspects of the transition is financial support; a consistent theme throughout all of the interviews (J1D 2014; F2V 2014; C3V 2014). In a report by the Center for Investigative Reporting (2013), VA documents reveal that the delay for processing and receiving disability through the VA can take up 327 days. In major cities, that processing time can take twice as long, with a wait time of 642 days in New York (Glantz 2013a). Disability pay can be major source of income for a veteran. Some veterans are still in transition and looking for work, while others are unable to work due to the very disability that discharged them from service. Disability compensation may be the only income for a veteran (C3V 2014). With an increase in risk of PTSD and the comorbidity of other disorders, suicide and homelessness tend to be common extreme outcomes among veterans (Taylor 2006). The lack of income can lead to an aggregated sense of hopelessness, depression, homelessness, and suicide. X4I (2014) commented that upon his release from active duty service, and diagnosed with PTSD, he suffered increased depression and anxiety.

For some veterans, suicide and homelessness are additional effects from physical, emotional, and financial crisis. In 2013, an estimated 50,000 Iraq and Afghanistan veterans are homeless or in a federal program (Zoroya 2014). Additionally, an average of 22 veterans commit suicide each day according to Iraq and Afghanistan Veterans of America (IAVA). An estimated 1,892 veterans committed suicide from January to March 2014 (Good 2014). A survey conducted by the Washington Post and the Kaiser Family Foundation found that 51 percent personally know a service member or veteran who

served in Iraq or Afghanistan who has attempted or committed suicide. These strikingly high numbers supports the importance of financial security and supports the possible effects the lack of VA disability compensation has on veterans transitioning out of service.

The case manager, C3V, described numerous financial support programs available for veterans who need immediate financial assistance. The assistance can be used as a temporary fix for bills or sustainment, and all programs have specific requirements and qualifying criteria (C3V 2014). C3V had such extensive knowledge on the programs that it became apparent how often financial support was needed and used. The case manager is a central point of contact that can assist in connecting veterans to financial services.

It must be mentioned, that command influence during the pre-separation is critical to the transition process. Command support has direct influence on the amount of time a soldier is allotted to focus on transition and separation. All three case managers discussed instances where commands did not fully support a soldier. X4I mentioned that his direct supervisor made him attend ACAP and focus on his separation, which was a great support to him making his transition. Command support was not the main focus of this thesis, and questioning did not go in depth on this subject; however, command impact on separation is important to identify.

What are the Major Aspects of this Process
that Impede Behavioral Health Healing?

Separating from the Army is a major life change regardless of the reason or status of the service member's departure. By it's vary nature, a major life change can bring

about stress and anxiety over the future. Evaluating the same separation process for a veteran with diagnosed behavioral health issues may reveal that stress and anxiety compound PTSD or mTBI symptoms that are already present. This was the case for X4I (2014), who honestly relayed his dealings with depression and anxiety during his separation. He was unsure about his future, which raised his stress and anxiety; he did not feel that six months was enough time to properly separate and prepare for a life outside the Army. X4I identified that ACAP, although a great resource, provided an overabundance of information that left him overwhelmed.

The ACAP is part of the pre-separation process and provides critical services and resources to include VA and employment related subjects. All three case managers had stories about soldiers and veterans claiming that VA information on fundamental aspects of separation was not provided. There appears to be a discrepancy between the information provided by the ACAP services and veterans ability to retain that information.

One cause for this discrepancy may be due to the amount of information provided by ACAP. ACAP attempts to exercise due diligence by providing comprehensive resources to aid in separation. X4I identified that each ACAP seminar or class had corresponding informational paperwork, which accumulated quickly and became disorganized and overwhelming.

Soldier's responsibility and ability to retain and handling the given transition information is the other half to this equation. The soldier's responsibility to the ACAP process was highlighted by F2V. F2V recommended that soldiers must listen and pay attention to the information provided. This recommendation appears to be very simplistic

and obvious; however some ACAP briefs and seminars are eight hours a day for three or five days in duration. ACAP services the entire force, regardless of service member's disability status. A soldier with PTSD may be unable to concentrate or process information for large amounts of time, may feel restricted by the environment, or may be depressed or agitated, even angered, which does not aid in retention of ACAP, VA, or employment information provided.

Upon separation, the wait time for appointments was one of the top issues relating to the impediment of behavioral health healing. In order to see a behavioral health specialist, an initial primary health care appointment is mandatory. Wait times for appointments can be two weeks or three months depending on the clinic and schedule (F3V 2014). "The VA's standard is for veterans to receive their initial appointment within 14 days of scheduling" (Siegel 2014). X4I (2014) has to wait six weeks before his initial appointment, which does not include his follow on appointment with a behavioral health specialist.

At the time of this research, the VA is currently undergoing a massive investigation on wait times for appointments and the implications on treatment. In Phoenix, Arizona a VA whistleblower came forward and identified that there was a secret waiting list that hides appointment delays (Siegel 2014). Results from the VA inquiry are not completed, however the appointment wait time can have serious consequences on those seeking treatment, and those suffering from PTSD or mTBI.

The wait time for financial support can also be a tertiary effect to the transition process and have a negative effect on behavioral health healing. Financial security, as discussed in question number two above, is a continual theme throughout the entire

process that has major impact on the veteran and veteran's family during the transition to civilian life.

What can Soldiers do to Improve their Chances of a Successful Transition?

There are two prongs to the transition process: the process itself and the soldier. ACAP, the VA, and case managers can only provide resources and services. The soldier must work in conjunction with the process and be active during the transition. The responsibilities of the soldier and the veteran are critical. At the initial IDES, MEB phase, it behooves the soldier to build a comprehensive pan. Planning to transition and creating a plan for a transition greatly improves a soldier's chance for a successful transition. J1D (2014) mentions that the most successful soldiers had a written, organized plan to assist them in their separation and transition. A written plan helped provide a picture of their future and helped the soldier visualize the desired end goal upon completion. Additionally, a plan helped reinforce the soldier's responsibilities to the process. When asked, what soldiers can do to make the transition easier, X4I says to "get in the mind set and start thinking and planning." X4I had six months for the transition, which he says was not enough time. There is such limited time to separate, that being proactive during the transition period is crucial.

Proactiveness also alludes to the veteran to contacting the VA directly. The transition from IDES to the VA is not the same for every soldier; therefore, if the VA does not contact the soldier during IDES, it is important that the individual contacts the VA. The veteran should become vested in the VA system early. If a veteran waits to enroll in the VA until an medical issue arises, the veteran then faces the wait time issues

as described above. Being proactive can stop that initial wait time from compounding, allowing for appointments with specialty clinics to be scheduled.

Veterans should be honest about health concerns and issues. Honest answers to the pre-screenings for PTSD and mTBI help the case manager provide services and a treatment plan for the veteran (C3V 2014). C3V also recommended that veterans should be open to services. If a veteran is unsure about a service provided, or counseling, "I always tell them to try it. They can always quit, but if they try it, they may find that it helps." Understanding that the VA provides an abundance of services, the key for a successful transition, is for the veteran to use the VA and try the services provided.

Veterans with PTSD and mTBI may not be in a positive mental state to plan or be proactive in the transition process. Diminished interest in participating in significant activities, detachment, agitation, and the inability to concentrate are all symptoms of PTSD that directly counter the recommendations for veterans. C3V acknowledged that some veterans will take months before they seek treatment for PTSD and by that time the veteran has coped in other manners such as substance abuse. Understanding the challenges PTSD veterans face during a transition C3V said that the VA case manager informs the veteran what resources are available when the veteran is ready.

What Actions by the Behavioral Health Providers Facilitate a Successful Transition?

This question is the final secondary question that was not directly asked during the interviews. The question did get directly addressed in the interview with X4I (2014). Seeing a behavioral health provider during pre-separation, was the one way which X4I was able to cope with his depression, anxiety, and separation from the military. The

behavioral health provider was able to talk X4I through his transition and provide a positive perspective, which helped X4I address his fears and cope with the change. Gleaning information from X4I, the behavioral health providers for soldiers diagnosed with PTSD and mTBI can assist in preparing the soldier for the transition, engaging the mental facilities that can help a soldier cope with the change of separating from the Army.

Summary

Chapter 4 presented the interview questions and main results of this study. It reviewed the transition process from the point of release from active duty service into the VA. It covered the roles and responsibilities of the case manager, who appears vital in the process to provide assistance and support as needed by the veteran. The major negative trends of the process that continued to be identified were the long appointment wait times and financial veteran disability support, both of which have a direct impact on the veteran and can contribute to the behavioral health of the veteran. Unemployment, underemployment, homelessness, and suicide may be tertiary effects of a poor transition process, which includes the processing of veteran disability, and ultimately security and peace of mind.

A veteran must use the transition process in place, regardless of the merit of the process; therefore a veteran has responsibilities to his or her own transition into the civilian life. Creating a plan to transition can greatly aid in making a transition and may ease the pain of such a significant life event. Participating and using the services provided can aid in continued support during the transition; however, the intended population for this study, veterans diagnosed with PTSD and mTBI, may be incapable of planning a

transition; therefore, it is critical to have an engaged case manager and it is important that resources are identified for the veteran to use when he or she is ready.

The transition process for an IDES completed veteran is extensive and complicated. Chapter 5 provides additional analysis of the data, implications, and recommendations for the process. Additionally it provides recommendations for future research on this topic.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

> It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped.
>
> — Former Vice President, Hubert H. Humphrey's Address to Democratic National Convention, 1976

Introduction

From 2002 to 2011, nearly 1.2 million out of 2.1 million service members have separated from the active duty military. Approximately 400,000 of those separated from service were diagnosed by the VA with a mental health disorder, the most prominent cases being members suffering from PTSD and depression (Tanielian and Jaycox 2008). Over a decade of DoD studies and findings recommends ways in which to "expand its capabilities to support the psychological health of its service members and their families" (Department of Defense 2007, 1). This thesis addressed the systemic issues of the transition process and proposes that the negative trends of homelessness, suicide, financial hardships, and unemployment may be symptomatic of a weak transition process. Creating a defined transition process from DoD agency to the VA for men and women suffering with PTSD and mTBI may impact the psychological health and wellbeing of the veterans for the better. The interviews answered the secondary questions of this thesis. Conclusions and recommendations for each secondary question are presented and the results will address the primary thesis question.

Discussion 1

What is the Existing Process for Members Separated for Behavioral Health (PTSD and mTBI) Issues?

The entire transition identified in chapter three and further expanded upon in chapter four covers the process from DoD to VA. The IDES and ACAP processes are just as important as the steps that occur upon release from active duty when diagnosed with PTSD or mTBI. The pre, final, and post separation steps provide a separation framework that every soldier must complete. This framework is used to informally tailor a separation for soldiers undergoing an MEB, PEB, and separation from active duty. IDES documents broadly review the key points of separation, such as the 90 day mandatory separation time but do not clearly define the transition process, which appears to take second priority to the MEB and PEB.

The actual transition between DoD and VA does not always occur, which may be due to several reasons. The first is that the DoD representative, IDES representative, or even PEBLO are not responsible for contacting the VA to transition the soldier into the VA; this is the main responsibility of the VA LNO, who may or may not be assigned to a DoD Medical Treatment Facility (MTF). Second, the VA LNO may contact the VA case manager; however, the soldier is unable to be reached. Several examples were provided in which soldiers did not leave proper contact information, or that the soldier did not answer or return phone calls from the VA case manager (F2V 2014; C3V 2014). Both possibilities impede the system and postpone the transition of the soldier into the VA and impact the new veteran being vested into the VA system.

Recommendation 1

The pre-separation process is such an important component to the transition, but it is not well integrated into the IDES system. DoD and IDES regulations should provide a standard concept for pre-separation to occur within IDES according to the already designated timeline. A standard concept will create a defined process allowing the soldier ample time to attend ACAP, create a transition plan, and mental prepare to be separated from the military. Regulations should also mandate the handover of an IDES soldier from DoD to the VA. It has become apparent that the handover between DoD and the VA is extremely beneficial to the veteran and the veteran's behavioral health and appointment timeliness. The soldier may choose to opt out and make arrangements with the VA on his or her own, however the handover between agencies should be mandated. The DoD transition process must occur in tandem with the VA process in order to create a seamless handover, creating a smooth transition for the veteran.

The position of the VA LNO must be embedded into every MTF. This position appears critical to the process. The VA LNO inputs all IDES documents into the computer system and is responsible for informing the case manager of an inbound veteran (F2V 2014). Thus reiterating the importance of the handover in relation to getting the veteran into the VA system.

Discussion 2

What are the Case Managers' Responsibilities and Actions that Facilitate a Successful Transition?

The case manager is a critical VA position for the transition of veterans from IDES DoD into the VA. Qualitative data suggests that contact made early between the

case manager and veteran can lead to a shorter initial wait time for the primary appointment and can provide a central contact and support for the veteran. The case manager is familiar with outside resources that may provide temporary financial assistance for a veteran.

Recommendation 2

This research recommends increasing the number of case managers who provide both case and care management (C3V 2014. Case managers appear critical to the transition process and a central station on which to go to for assistance. Both VA interviewees said that additional manpower could be used in order to provide quality time to each patient. F2V (2014), mentioned that the VA "can always do more, with more". and C3V mentioned that more staff would allow case managers to invest in the patients and provide care management.

Discussion 3

What Soldiers' and Veterans' Actions Facilitate a Successful Transition?

It is important to identify the role that soldiers have to the transition process. Soldiers must be proactive during the transition process to create opportunities for a successful transition. One cannot plan for everything, but to be prepared is indicative of success. An issue is that the main population addressed in this thesis is diagnosed with PTSD and mTBI, which may be counter to proactive planning.

Recommendation 3

Recommendation three attempts to provide a specific measures that will counter the PTSD and mTBI symptoms that impair soldiers from planning a successful transition. The PEBLOs and case managers act as a forcing function to facilitate a diagnosed veteran to plan and complete the transition process. These personnel already go through this process with the patients. Behavioral health providers and command support may round out and provide much needed emotional support during a transition. Behavioral health providers can prepare soldier mentally for the separation from the Army. Command support can provide supervision from leadership who can review the separation plan and review the same checklist provided by IDES and ACAP. Command support will also need to provide a positive command support for the transition, and can be additional support during a difficult time. The challenge for the command will be establishing a positive command climate and a positive command transition program in order to make command support successful.

Additionally, the pre-separation process must be directed and tailored toward soldiers with behavioral health diagnosis. ACAP should re-evaluate the length and duration of classes and should limit and organize the amount of information, and supporting documentation and leaflets provided to the soldier. Simply providing a pre-made resource book, with all subsequent information may reduce anxiety and aid in planning.

Discussion 4

What are Common Trends and or Issues that Improve or Impede Behavioral Health Healing for Soldiers?

Financial stress, unemployment, and VA disability all appear to be interrelated and are the top issues which impede a successful transition and affect behavioral health healing. This was directly corroborated by C3V (2014) stating that the three biggest issues veterans faced were "employment [or the lack of employment], finances, and underemployment". Financial strain on top of PTSD, and the comorbidity of other disorders, has a direct causal link to homelessness and suicide rates seen in veterans (Taylor 2006).

Appointment wait times was a major impediment to behavioral health healing if the veteran is unable to schedule a specialty clinic behavioral health care appointment. Scheduling for the VA enrollment process shows that the wait time for the initial appointment can average six weeks; additional time would then be added to schedule a behavioral health clinician. Wait times have a direct affect on behavioral health healing for PTSD and mTBI issues.

The ACAP is a great source of information, services, and resources for the outbound soldier. It is available during the IDES process and is available and open to veterans up to six months after separation. Information provided by ACAP aids in transition, employment, and VA services, all aimed at benefiting the soldier after service. The program provides an abundance of information. ACAP itself does not have regulatory guidelines integrating it into the IDES system to provide a deliberate transition process for the soldier.

Case managers appear to be a strong source that has great potential to assist in behavioral health healing. The roles and responsibilities of the case manager frame a logical, central point of contact to be a base of support through the entire transition process and beyond. Because the main interviewees were within the case manager realm, this may have influenced the results and the following recommendation. This area will be discussed further within recommendations for future research.

Recommendation 4

Identifying a sole cause of financial strain amongst transitioning soldiers is near impossible. There are a few recommendations across the wide range of possibilities to aid in tempering the financial stress. First, ACAP provides financial planning and resume writing classes to prepare soldiers for their financial and employment future. The veteran's responsibility during ACAP is to plan early. X4I, a Captain, recommends that he should have planned and prepared upon the initial notice that he may no longer be in the military. He also recommends that the ACAP resume writing class be updated because the resume tips "appear to be outdated" and he had to completely change his resume when looking for employment.

The VA disability claims process has been identified as a major concern to the VA. Restructure and a new computer system has increased the processing of compensation claims and reduced the wait from 12 months to eight months. The goal is to have the compensation process and disability claims to the veteran within four months by 2015 (Glantz 2013a). The VA is currently aware and is trying to rectify the situation.

The VA is also investigating appointment wait times. Under the current transition process, it is critical that the IDES soldier makes contact with the VA and should be

mandatory to the transition process of every soldier within IDES. The soldier can choose to opt out after separation from the Army; however, the government has due diligence to conduct a proper hand over. DoD and the VA conducting a mandatory handover, supports the national priority to provide health care for the nations soldiers and veterans. Additionally pre-enrollment in the VA would help in the transition process. Early enrollment may help with the transition; however, VA wait time issues appear to be systemic and the VA is conducting in depth research on the subject.

The ACAP and IDES need regulatory guidelines on how both can integrate in order to create a deliberate transition process. ACAP should also tailor the program to soldiers undergoing MEB and PEBs. It is extreme to recommend a tailored program for separate diagnosis such as PTSD and mTBI; therefore, the recommendation pertains to the soldiers going through the IDES process. Classes should be kept short and organized binders with resources and information should be provided. Information should be repetitive in nature and individual plans should be reviewed with an ACAP case manager in incremental steps.

Finally, case managers within the VA should be increased. More research should be conducted on this position; however, the current recommendation is that the case manager can provide vital linage between the VA and the veteran. Case managers can provide information, resources, and support that are critical during the transition process.

Discussion 5

What Actions by the Behavioral Health Providers Facilitate a Successful Transition?

This question was addressed in chapter four and it illustrated that behavioral health providers can aid the soldier by mentally preparing him or her for the transition. Mental preparation appears to be just as important to the transition process.

Recommendation 5

Recommendations for the behavioral health provider are difficult to make. DoD and VA Behavioral health providers are extremely busy; therefore, adding mandatory pre-separation counseling sessions, even limited in duration, may be a difficult task. The behavioral health provider does provide an important aspect to the mental preparation of a separation from the Army and is able to provide the proper support for a soldier diagnosed with PTSD and mTBI. If the behavioral health provider is part of the IDES process and incorporated as a mandatory appointment prior to release, it may benefit the soldier and provide an added benefit to the IDES process. This paper did not focus on the IDES process and it is outside the scope of this research.

Summary of Primary Question

This research revealed five major factors that facilitate positive behavioral health and created a successful transition into civilian life for soldiers diagnosed with mTBI and or PTSD who were separated from the Army through the IDES process. The first two factors are the VA case manager and the soldier; they both have responsibilities crucial to the transition process and must actively be engaged throughout the separation process from one system into the other. The third factor is the individual transition plan, whether

created using ACAP or VA resources, shows that an executable plan can create a successful roadmap to prepare a soldier to handle the stress and outside obstacles that may appear. Next is the handover conducted by the DoD into the VA. The VA LNO appears to be a linchpin in the system that can provide a link, if used by the veteran, from the Army into the VA. And finally, the Behavioral health care during the process provided by the behavioral health providers appears to greatly assist in the veterans ability to understand, cope, and continue on during the stressful transition process.

Future Study Recommendations

Conducting this research identified three main areas for continued research and future study. The first is to expand upon this study, which may support or counter the results and findings. Conduct a larger study and survey a larger population of case managers, soldiers, and veterans in order to find quantitative measurements on trends in the transition process. Additionally, extend this study to all service components and confirm that these issues affect veterans regardless of service affiliation.

This research also indicated a need for continued research on two specific positions: the VA LNO and the VA case manager. The current hypothesis is that the VA LNO is a critical position that should be at every DoD MTF. Compare DoD MTFs that do and do not have VA LNOs. Then, research the criticality of the VA LNO position in the handover process to the VA and the implications this position has to the entire transition process. It is important to investigate the importance of the VA case manager in relation to the transition process; therefore, identify the positive and negative aspects of case manager and evaluate the necessity of the case manager to the transition process.

Finally, the third extended possibility for future study is to identify the implications that the command and pre-separation process has on the desire to plan and transition into the VA. The hypothesis is that negative command support and a poor pre-separation process will negatively affect the transition process and the veteran's desire to seek out assistance and help for both physical and behavioral health care.

Research Summary and Conclusion

The transition process out of the military is a major life transition. It can be fraught with stress, anxiety, and the future unknown. Executing the transition process can be even more grueling to a soldier diagnosed with PTSD and or mTBI. The current transition process for a soldier undergoing the IDES process diagnosed with PTSD and mTBI, must be evaluated and understood from the DoD IDES, ACAP, and separation process. This process frames the transition process out of the Army and into the VA.

The handover from DoD to the VA is critical to the transitions, as are the major players: the VA LNO and the VA case manager. Both positions set up the veteran to make a smooth transition into the VA system. The VA case manager is a central figure in the transition and is able to provide services and resources that directly contribute to the wellbeing of the veteran and support a successful transition to civilian life. The veteran must be a willing participant through the transition process. A success transition is often found when a plan is created and executed.

Finally, major issues found within the veteran population such as homelessness, suicide, financial hardships, and employment issues may be indicative of a systemic issue within the transition process rather than caused by PTSD or mTBI. This is not to ignore PTSD or mTBI symptoms and severity. The process that transitions active duty military

members out of service and into society may have direct implications on the above identified issues. A major connection between VA disability and compensation claims to financial instability, homelessness, employment, and suicide were presented in this research and supports the premise of changing the process to change the outcome.

The President, Congress, the Secretary of Defense, and military leadership have deliberately addressed the importance of the health, welfare, and well-being of military members, veterans, and family members of the military. Providing care for our veterans will show society that the government takes care of veterans, and will perpetuate continued military service; therefore, it is critical to review and evaluate the process in which soldiers become veterans and transition out of the military to become a civilian.

APPENDIX A

PTSD CHECKLIST–MILITARY (PCL-M)

PTSD Checklist – Military Version (PCL-M)

Name: _____ Unit: _____
Best contact number and/or email: _____
Deployed location: _____

Instructions: Below is a list of problems and complaints that veterans sometimes have in response to a stressful military experience. Please read each one carefully, put an "X" in the box.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful military experience?					
2.	Repeated, disturbing *dreams* of a stressful military experience?					
3.	Suddenly *acting* or *feeling* as if a stressful military experience *were happening again* (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful military experience?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful military experience?					
6.	Avoid *thinking about* or *talking about* a stressful military experience or avoid *having feelings* related to it?					
7.	Avoid *activities* or *talking about* a stressful military experience or avoid *having feelings* related to it?					
8.	Trouble *remembering important parts* of a stressful military experience?					
9.	Loss of *interest* in things that you used to enjoy?					
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short?*					
13.	Trouble *falling* or *staying* asleep?					
14.	Feeling *irritable* or having *angry outbursts?*					
15.	Having *difficulty* concentrating?					
16.	Being "*super alert*" or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

Has anyone indicated that you've changed since the stressful military experience? Yes __ No__

APPENDIX B

ACAP Pre-Counseling Checklist

PRESEPARATION COUNSELING CHECKLIST
FOR ACTIVE COMPONENT (AC), ACTIVE GUARD RESERVE (AGR), ACTIVE RESERVE (AR), FULL TIME SUPPORT (FTS), AND RESERVE PROGRAM ADMINISTRATOR (RPA) SERVICE MEMBERS

(Please read Privacy Act Statement and Instructions in Section III before completing this form.)

SECTION I - PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1142, Preseparation Counseling; E.O. 9397, as amended (SSN).
PRINCIPAL PURPOSE(S): To record preseparation services and benefits requested by and provided to Service members; to identify preseparation counseling areas of interest as a basis for development of an Individual Transition Plan (ITP). The signed preseparation counseling checklist will be maintained in the Service member's official personnel file. Title 10, USC 1142, requires that not later than 90 days before the date of separation, for anticipated losses, preseparation counseling for Service members be made available. For unanticipated losses, preseparation counseling shall be made available as soon as possible.
ROUTINE USE(S): None.
DISCLOSURE: Disclosure of SSN is mandatory. Disclosure of other information in Section II is voluntary; however, it may not be possible to initiate preseparation counseling and other transition assistance services or develop an Individual Transition Plan (ITP) for a Service member if the information is not provided.

SECTION II - PERSONAL INFORMATION *(To be filled out by all applicants)*

1. NAME a. Last Name	b. First Name	c. Middle Initial	2. SSN	3. GRADE	4. DATE OF BIRTH (YYYYMMDD)

5. SERVICE (X one)	5.a. COMPONENT	6. DUTY STATION	7. ANTICIPATED DATE OF SEPARATION (YYYYMMDD)
ARMY	AC	a. MILITARY INSTALLATION/CITY	
MARINE CORPS	AGR		
NAVY	AR	b. STATE / c. ZIP CODE	7.a. I AM (X one)
AIR FORCE	RPA		Retiring / Separating Involuntarily
COAST GUARD	FTS		Separating Voluntarily

8. DATE CHECKLIST PREPARED (YYYYMMDD)

8.a. Place an X in this box ONLY if you have 89 days or less remaining on active duty before separation or retirement. *(Please read the following instructions: If separating or retiring and you have 89 days or less remaining on active duty before your separation or retirement, why was your preseparation counseling not conducted earlier? Please go to Section VI - REMARKS and check the response that best describes why preseparation counseling was not conducted earlier.)*

9. Is your spouse/family member/legal guardian/designee present during preseparation counseling? *(X one)* — YES / NO / N/A

9.a. Are you willing to be contacted after separation or retirement regarding the value of the transition assistance programs and services you received? *(X one)* — YES / NO

SECTION III - INSTRUCTIONS

All transitioning Service members shall read these instructions before completing Sections IV, V, and VI of this form. After being counseled, Service member shall sign and date the form in items 28.a. and 28.b.

This form will be used for Active Component (AC), Active Guard Reserve (AGR), Active Reserve (AR), Full Time Support (FTS), and Reserve Program Administrator (RPA) Service members.

(1) Items checked "YES" indicate that you require additional information or referral to a subject matter expert on the installation or to an appropriate person in another agency or organization outside of DoD or attendance at a scheduled employment or VA session (Section IV).

(2) Shaded areas on the form mean: (a) the information is not applicable (example: item 11.b. is shaded under "Spouse" because DD Form 2586, "Verification of Military Experience and Education - VMET", does not apply to spouses); or (b) the item is referring to a Web site address and URLs require no further explanation. URLs are provided so Service members can research information at their leisure on a given topic or subject.

(3) **Department of Labor TAP Employment Workshop**: In accordance with DoDI 1332.35, AC, AGR, AR, FTS, and RPA separating and retiring Service members who check "YES" in item 11.a. on DD Form 2648, "Preseparation Counseling Checklist", shall be released to complete the Department of Labor (DOL) Transition Assistance Program (TAP) Employment Workshop in its entirety. Service members will be exempt from normal duty the full 24 hour period of each DOL workshop day and the 12 hours immediately preceding and following the DOL workshop. In the event that a DOL Workshop is unavailable, the Service member will attend a military equivalent employment workshop conducted by the Military Services.

(4) **Veterans Benefits Briefing:** In accordance with DoDI 1332.35, all separating and retiring Service members who check "YES" in item 19 shall be released to complete the Veterans Benefits Briefing sponsored and offered by the Department of Veterans Affairs (VA) in its entirety. Service members will be exempt from normal duty the full 24 hour period of each VA Benefits Briefing day and the 12 hours immediately preceding and following the VA Benefits Briefing.

(5) **Disabled Transition Assistance Program (DTAP):** In accordance with DoDI 1332.35, all separating and retiring Service members who check "YES" in item 20 (with special emphasis on Wounded, Ill, or Injured) who have or think they have a service-connected disability, are awaiting a medical discharge, or have incurred an injury or illness while on active duty, or aggravated a pre-existing condition, and those referred to a Physical Evaluation Board or placed in a medical hold status by their Service, shall be released to complete the DTAP briefing sponsored by VA. Spouses/Family Member/Legal Guardian/Designee are encouraged to attend the DTAP briefing. Service members will be exempt from normal duty the full 24 hour period of each VA DTAP Briefing day and the 12 hours immediately preceding and following the VA DTAP Briefing.

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PRESEPARATION COUNSELING CHECKLIST FOR AC, AGR, AR, FTS, AND RPA SERVICE MEMBERS	NAME *(Last, First, Middle Initial)*	SSN

SECTION IV

Please indicate *(by checking either YES or NO)* whether you *(or if accompanied by your spouse/family member/legal guardian/designee if applicable)* desire additional counseling for the following benefits and services to which you may be entitled. All benefits and services checked YES should be used to develop your Individual Transition Plan (ITP). The following benefits and services available to all Service members, unless otherwise specified, will be explained by the Transition/Command Career Counselor.

	SERVICE MEMBER		SPOUSE		REFERRED TO
	YES	NO	YES	NO	
10. EFFECTS OF A CAREER CHANGE					
11. EMPLOYMENT ASSISTANCE					
a. Do you want to attend the Department of Labor sponsored Transition Assistance Employment Workshops or Service sponsored Transition workshops/seminars?					
b. Verification of Military Experience and Training (VMET) (DD Form 2586). Do you want a copy of your VMET document? If yes, go to www.dmdc.osd.mil/vmet to print your VMET document and cover letter.					
c. Counselor will provide information on civilian occupations corresponding to Military occupations (see Occupational Information Network (O*NET website) at www.online.onetcenter.org/crosswalk and related assistance programs) and civilian occupations related to assistance programs.					
(1) Licensing, Certifications and Apprenticeship Information.					
(a) Department of Labor www.careeronestop.org/CREDENTIALING/CredentialingHome.asp					
(b) U.S. Army Credentialing On-line https://www.cool.army.mil					
(c) U.S. Military Apprenticeship Program https://usmap.cnet.navy.mil/usmapss					
(d) DANTES www.dantes.doded.mil/dantes_web/danteshome.asp					
(e) Navy Cool Website https://www.cool.navy.mil					
d. TurboTAP.org (www.TurboTAP.org) and other programs, tools, and resources					
(1) Employment Hub www.turboTAP.org/portal/transition/resources/Employment_Hub					
(2) Hire Vets First www.hirevetsfirst.dol.gov/					
(3) State Job Boards www.careeronestop.org/jobsearch/cos_jobsites.aspx					
(4) DOL REALifelines www.hirevetsfirst.dol.gov/realifelines/index.asp					
e. Public and Community Service Opportunities www.turboTAP.org/portal/transition/lifestyles/Employment/Public_and_Community_Service_PACS_Registry_Program					
f. Teacher and Teacher's Aide Opportunities/Troops to Teachers www.proudtoserveagain.com					
g. Federal Employment Opportunities					
(1) www.usajobs.opm.gov					
(2) www.go-defense.com					
(3) Information on Veterans Preference in Federal Employment					
(4) Information on Veterans Federal Procurement Opportunities					
(5) Office of Personnel Management (OPM) Special Hiring Authorities					
h. Hiring Preference in Non-Appropriated Fund (NAF) jobs (Eligible Involuntary Separatees)					
i. State Employment Agencies					
(1) Career One Stop Centers www.careeronestop.org/jobsearch/cos_jobsites.aspx					
(2) Workforce Investment Act (WIA)					
j. Information concerning veterans small business ownership and entrepreneurship programs					
(1) Small Business Administration www.sba.gov/aboutsba/sbaprograms/ovbd/ and www.score.org SBA Patriot Express Loan					
(2) National Veteran's Business Development Corporation www.veteranscorp.org					
k. Information on employment and reemployment rights and obligations (USERRA) for Active Duty Service Members *(Chapter 43, Title 38 U.S. Code)*					
l. Information on "Priority of Service" for veterans in receipt of employment, training, and placement services provided under qualified job training programs of the Department of Labor					

PRESEPARATION COUNSELING CHECKLIST FOR AC, AGR, AR, FTS, AND RPA SERVICE MEMBERS	NAME *(Last, First, Middle Initial)*	SSN

SECTION IV *(Continued)*	SERVICE MEMBER		SPOUSE		REFERRED TO
	YES	NO	YES	NO	
12. RELOCATION ASSISTANCE ***NOTE: Status of Forces Agreement limitations apply to overseas Service members.**					
a. Permissive (TDY/TAD) and Excess leave					
*b. Travel and Transportation Allowances (see Note above)					
13. CONTACT INFORMATION FOR HOUSING COUNSELING ASSISTANCE portal.hud.gov/portal/page/portal/HUD					
14. EDUCATION/TRAINING					
a. Education benefits (Post 9-11 GI Bill Chapter 33), (Montgomery GI Bill Chapter 30), (Veterans Educational Assistance Program), (Vietnam-era, etc.) www.gibill.va.gov					
b. U.S. Department of Education Federal Aid Programs www.FederalStudentAid.ed.gov					
c. Other Federal, State, or local education/training programs and options					
15. PHYSICAL AND MENTAL HEALTH WELL-BEING					
a. Information on availability of Healthcare and Mental Health Services (Post-traumatic stress disorder, anxiety disorders, depression, suicidal ideations, combat operational/stress, or other mental health conditions associated with service in the Armed Forces)					
(1) Transitional Healthcare Benefit/TRICARE (for eligibility and additional information go to: www.tricare.mil or www.tricare.mil/Factsheets/browsetopic.cfm) (click on Transitional Assistance Management Program)					
(2) VA Health Administration www1.va.gov/health/index.asp					
(3) VA Vet Center www.vetcenter.va.gov					
(4) State and local healthcare and mental health services					
b. Describe healthcare and other benefits to which the member may be entitled under the laws administered by the Secretary of Veterans Affairs - www.va.gov					
(1) VA health care					
(2) VA dental care					
16. HEALTH AND LIFE INSURANCE					
a. Continued Health Care Benefits Program - Option to purchase 18-month conversion health insurance. Concurrent pre-existing condition coverage with purchase of conversion health insurance www.tricare.mil/mybenefit/home/overview/SpecialPrograms/CHCBP					
b. Veterans Group Life Insurance (VGLI) www.insurance.va.gov/sglisite/vgli.htm and www.turboTAP.org websites					
c. Servicemembers' Group Life Insurance (SGLI) www.insurance.va.gov/sglisite/default.htm and www.turboTAP.org websites					
d. Traumatic Injury Protection Program (TSGLI) www.insurance.va.gov/sglisite/tsgli/expandedbenefits.htm and www.turboTAP.org websites					
e. Family Servicemembers' Group Life Insurance (FSGLI) www.insurance.va.gov/sglisite/fsgli/sglifam.htm and www.turboTAP.org websites					
f. Service-Disabled Veterans Insurance (S-DVI) www.insurance.va.gov/inForceGliSite/buying/SDVI.htm and www.turboTAP.org websites					
g. Veterans' Mortgage Life Insurance (VMLI) www.insurance.va.gov/inForceGliSite/buying/VMLI.htm and www.turboTAP.org websites					
h. For more information on Veterans Life Insurance, visit: www.insurance.va.gov					
i. Transitional Health and Dental Care Benefit - for eligibility criteria and additional information, go to: www.tricare.mil and www.tricare.mil/dental/TRDP_Eligibility.cfm					
17. FINANCES					
a. Financial Management (TSP, Retirement, SBP, military vs. civilian pay and benefits)					
b. Separation pay (Eligible Involuntary Separatees)					
c. Unemployment Compensation					
d. General money management (budgeting, debt reduction)					
e. Personal savings and investing					

PRESEPARATION COUNSELING CHECKLIST FOR AC, AGR, AR, FTS, AND RPA SERVICE MEMBERS	NAME *(Last, First, Middle Initial)*	SSN

SECTION IV *(Continued)*	SERVICE MEMBER		SPOUSE		REFERRED TO
	YES	NO	YES	NO	
18. RESERVE AFFILIATION					
19. Do you want to attend the Veterans Benefits Briefing? (See section III, Instructions, item 4.)					
20. DISABLED VETERANS BENEFITS					
a. **Do you want to attend the Disabled Transition Assistance Program (DTAP) Briefing? See Section III - Instructions, item 5 and VA Vocational Rehabilitation and Employment Service at www.vba.va.gov/bln/vre**					
b. VA Disability Benefits www.vba.va.gov/VBA/benefits/factsheets					
c. Benefits Delivery at Discharge and Quick Start www.vba.va.gov/predischarge					
21. STATE VETERANS BENEFITS					
22. 2-YEAR COMMISSARY AND EXCHANGE PRIVILEGES (Eligible Involuntary Separatees)					
23. LEGAL ASSISTANCE					

24. POST GOVERNMENT (MILITARY) SERVICE EMPLOYMENT RESTRICTION COUNSELING

Information on post government (military) employment counseling (restrictions on employment, imposed by statute and regulation) shall be conducted by Services as appropriate. Transition/Command Career Counselors shall refer separating and retiring Service members to an installation legal office (Staff Judge Advocate or Counselor's Office) to ensure they receive a post government (military) employment restrictions briefing or counseling from an ethics official.

25. INDIVIDUAL TRANSITION PLAN (ITP)

a. As a separating Service member, after receiving Preseparation Counseling information and completing this checklist, you and your spouse/ family member/legal guardian/designee (if applicable) are entitled to receive assistance in developing an Individual Transition Plan (ITP) based on the areas of interest you have identified on this checklist. The Preseparation Counseling Checklist addresses a variety of transition services and benefits to which you may be entitled. Each individual is strongly encouraged to take advantage of the opportunity to develop an ITP. The purpose of the ITP is to identify educational, training, and employment objectives and to develop a plan to help you achieve these objectives. It is the Military Department's responsibility to offer Service members the opportunity and assistance they need to develop an ITP. It is the Service member's responsibility to develop an ITP based on his/her specific objectives and the objectives of his or her spouse, if appropriate.

Based upon information received during Preseparation Counseling, do you and/or your spouse/family member/ legal guardian/designee desire assistance in developing your ITP? If YES, the Transition staff/counselor/ Command Career Counselor is available to assist you (see www.TurboTap.org website).	SERVICE MEMBER		SPOUSE	
	YES	NO	YES	NO

b. To assist your transition counselor, choose the answer that best describes your post-military goal(s): *(X all that apply)*

- ☐ I already have post-military employment.
- ☐ I plan to get a job and start work as soon as possible.
- ☐ Other *(please describe/write in)*
- ☐ I plan to go to school and use my VA education benefits.
- ☐ I don't know what I plan to do.

SECTION V - LANGUAGE SKILLS/REGIONAL EXPERTISE

Counselors will ensure all transitioning Service members, Active, Guard and Reserve with language skills and/or regional expertise complete Item 26.

26. The Department of Defense and other Federal agencies have placed a high level of importance on critical foreign language skills and regional expertise to meet emerging requirements during times of need, crisis, and/or national emergency. The Department of Defense and other Federal agencies may want to contact you in the future to determine if you would be willing to volunteer your services or to offer you potential employment that would take advantage of your language proficiency and/or regional expertise.

a. Do you consent to being contacted by the Department of Defense for such purposes?		YES		NO
b. Do you consent to having the Department of Defense share your information with other Federal agencies for such purposes?		YES		NO

PRESEPARATION COUNSELING CHECKLIST FOR AC, AGR, AR, FTS, AND RPA SERVICE MEMBERS	NAME *(Last, First, Middle Initial)*	SSN

SECTION VI - REMARKS *(Attach additional pages if necessary)*

Complete the following ONLY if you placed an X in Item 8.a. *(See page 1, Section II, item 8.a.)*

27. MY COUNSELING WAS CONDUCTED 89 DAYS OR LESS BEFORE MY SEPARATION OR RETIREMENT BECAUSE OF: *(X one)*

- ☐ Mission requirements
- ☐ Personal reasons
- ☐ Medical separation/discharge
- ☐ Legal separation
- ☐ Change in career decision
- ☐ Other *(Please provide a brief explanation)*

28. SERVICE MEMBER ACKNOWLEDGEMENT

By signing and dating this form, you, the Service member, are acknowledging that you received Preseparation Counseling on the date below (item 28.b.), and that you understand the transition benefits and services available to assist you in your transition as required by Title 10, U.S.C., Chapter 58, Section 1142.

a. SERVICE MEMBER SIGNATURE	b. DATE *(YYYYMMDD)*	c. TRANSITION COUNSELOR SIGNATURE	d. DATE *(YYYYMMDD)*

APPENDIX C

INDIVIDUAL TRANSITION PLAN (ITP)

Individual Transition Plan
(ITP BLOCK 1)

Full Name: _____ Anticipated Separation Date: _____

Rank: _____ Unit: _____

Date attended Pre-separation Counseling: _____ (attach copy of DD Form 2648 / 2648-1)

List your top 3 Military Occupation Code(s) and Title(s):

- _____
- _____
- _____

TRANSITION PLANNING OVERVIEW

The key to a successful transition is planning, which requires a carefully thought out Individual Transition Plan (ITP). The ITP provides a framework to achieve realistic career goals based upon an assessment of your personal and family needs as well as your unique skills, knowledge, experience, interests and abilities. You create and maintain your ITP with assistance from your Transition Counselor.[1] using the following template. The ITP coincides with the Transition GPS (Goals, Plans, Success) outcome-based curriculum and provides a means to discover and explore your skills and interests which may lead to potential post-transition career paths. The ITP helps you identify critical activities associated with your transition and your Transition Counselor will assist you through the process of organizing your transition into manageable tasks. The ITP also helps you to establish a timeline for completing all required activities prior to separation – it is a living document and can be modified at any time. The ITP is the road map for attaining your employment, education, technical training, and entrepreneurial objectives and can help you make a successful transition to civilian life. To develop a successful ITP you must consider the following critical elements in your planning process:

I. Identify Post-transition Personal/Family Requirements (ITP Block 1)
- **Taking Care of Individual/Family Needs**
- **Assessing Benefits and Entitlements**
- **Getting Financially Ready**

II. Evaluate Military and Civilian Experience and Training (ITP Block 1)
- **Documenting Job Related Training**
- **Verifying Eligibility for Licensure, Certification**

III. Determine Post-transition Career Path
- **Finding a New Job (ITP Block 2)**
- **Continuing Your Education (ITP Block 3)**
- **Pursuing Technical Training (ITP Block 4)**
- **Starting a Business (ITP Block 5)**

IV. Create a Transition Timeline (ITP Block 6)
- **Identifying Planning Milestones**
- **Synchronizing Specific Activities**

[1] *Transition Counselor* is a term used by the Army & Air Force; *Advisor* (Marine Corps); *Command Career Counselor* (Navy); *State Transition Assistance Advisor* (National Guard); *Transition & Relocation Manager* (Coast Guard).

CAREER READINESS STANDARDS

Prior to completing your Individual Transition Plan (ITP), it is important to note that there are Career Readiness Standards you will be expected to meet. You will be required to provide documentation of meeting the following readiness standards to your Transition Counselor and Command representative prior to separation. These standards are designed to increase your ability to successfully overcome any challenges you may face in pursuit of your chosen career path. Some Career Readiness Standards apply to all career paths (Employment, Education, Technical Training and Entrepreneurship) while others only apply to a specific career path.

Career Readiness Standards Applicable to all Career Paths ***

- Attend Pre-Separation Counseling
- Complete Pre-Separation Counseling Checklist DD Form 2648 / DD Form 2648-1
- Register for VA Benefits (eBenefits)
- Prepare a Post-Separation 12-month budget reflecting personal and family goals and obligations
- Evaluate opportunities presented by continuing military service in a Reserve Component
- Crosswalk military skill set to civilian skills (MOS crosswalk) to include an evaluation of the demand for those civilian skills within the potential relocation destinations
- Identify and document requirements and eligibility for licensure, certification and apprenticeships at the potential relocation destinations
- Complete the Individual Transition Plan and provide documentation of meeting the Career Readiness Standards for the chosen career path

Employment Career Readiness Standards***

- Complete the employment readiness assessment prior to and after attending the Department of Labor Employment Workshop
- Prepare and submit the Job Application Package (e.g., create resume, identify references, submit at least two employment applications, and/or provide a job acceptance letter)
- Obtain a "Gold Card" Certificate from the Department of Labor

Education Career Readiness Standards***

- Complete an education needs assessment
- Identify, compare, and select academic institutions based on specific selection criteria
- Prepare and submit an Education Application Package (e.g., submit application to academic institution and/or provide an acceptance letter)
- Schedule one-on-one counseling with the academic advisor from the institution you will attend
- Connect with the Student Veteran Organization at your chosen institution

Technical Training Career Readiness Standards***

- Complete an education needs assessment
- Identify, compare, and select technical training institutions based on specific selection criteria
- Prepare and submit a Technical Training Application Package (e.g., submit application to technical training institution and/or provide an acceptance letter)
- Schedule one-on-one counseling with the academic advisor from the institution you will attend
- Connect with the Student Veteran Organization at your chosen institution

***** Career Readiness Standards are noted by 3 asterisks throughout the Individual Transition Plan**

PERSONAL ASSESSMENT

Section I. Identify Post-transition Personal/Family Requirements

A. Taking Care of Individual/Family Member Needs

❖ Identify individual/family needs such as medical care, expenses, and location of potential providers.

Notes:

❖ Identify extenuating individual/family circumstances (e.g. need to provide care for elderly parents, family business, exceptional family member needs, etc.).

Notes:

❖ Assess impact of individual/family requirements on relocation options (e.g. quality of local schools, availability of medical care, spouse employment opportunities, etc.).

Notes:

❖ Evaluate your immediate post-transition housing requirements. Determine how much living space you will require to safely house yourself, dependents, and personal items. Consider whether you may need to make more than one move or need to utilize temporary storage. Contact the housing referral office to identify local and remote housing options. The installation transportation office can provide detailed information about planning the movement and storage of your household goods. Visit the VA website: .http://www.benefits.va.gov/homeloans/. to get information on the VA home loan program.

Notes:

❖ Consider your post-transition transportation requirements. Determine if you have adequate reliable personal transportation to take you to and from your place of employment or school. Evaluate your commuting options and whether you need to purchase another vehicle(s) for your spouse and/or dependents. Identify your post-transition transportation expenses to include: purchase costs, vehicle registration, insurance, maintenance, fuel, etc. If you are disabled, determine if you are eligible for assistance in purchasing a vehicle and/or automotive adaptive equipment by visiting .http://www.warms.vba.va.gov/regs/38CFR/BOOKB/PART3/S3_808.DOC.

Notes:

- What person or persons do you go to for advice, personal counsel and/or mentoring when facing a difficult challenge or decision? Will you still have access to those persons after you separate from active duty? Consider what steps you need to take now to maintain contact.

Notes:

- With whom do you spend your leisure time now? Who is a part of your social network? How did you meet them? Determine the steps you need to take to continue these relationships or establish this type of support in the community where you will live post-separation.

Notes:

B. Assessing Benefits and Entitlements

❖ *** Evaluate the benefits (e.g. additional income, promotions, leadership and professional development opportunities, travel) associated with continuing your military service in either the Reserves or National Guard (if applicable). Consider the financial impact of continued entitlements such as medical and dental coverage, life insurance, military exchange, commissary, club privileges, recreational and athletic facilities. Contact the installation/ local recruiter to schedule an informational counseling session and identify potential units/positions.

Notes: Recruiter counseling date: _____ Financial impact: _____

- *** Register for your VA Benefits and assess their impact on future financial obligations: .www.ebenefits.va.gov.

Notes: Date applied for eBenefits:_____

C. Getting Financially Ready

- Identify anticipated financial obligations such as dependent college savings plan, retirement savings plan, utility security deposits, and additional commuting/transportation expenses (e.g., additional car payment, fuel, maintenance, insurance).

Notes:

- List required new civilian workforce wardrobe items and estimate expenses.

Notes:

- Develop and attach a plan to reduce/eliminate current debt: .https://powerpay.org/.

Notes: Date you reviewed your free credit report (.http://www.annualcreditreport.com/.):_____

- *** Develop a 12-month budget based on your current financial obligations (e.g., living expenses and indebtedness) as well as anticipated post-transition expenses. Determine if your expected post-transition income will adequately address anticipated financial obligations (e.g. housing, medical, food, insurance, transportation, costs of establishing a home, utility security deposits, etc.). Use the TurboTAP Financial Planning Worksheet for Career Transition at: .http://www.turbotap.org/export/sites/default/transition/resources/PDF/financial_planning_worksheet_fillable.pdf

- Attach a copy of your TurboTAP Financial Planning Worksheet for Career Transition and bring a copy to the Core Curriculum TAP workshop.

- Estimate your annual salary/income requirements: _____

Section II. Evaluate Military and Civilian Experience and Training

A. Documenting Job Related Training

❖ Check all that apply:

○ High School Graduate/GED	○ Training Certificates/ Licenses	○ Baccalaureate Degree
○ Vocational School	○ Apprenticeship	○ Post Graduate Studies
○ Relevant Training	○ Some College	○ Master's Degree
○ Technical Training	○ Associates Degree	○ Doctorate

❖ Gather documentation of your civilian and military experience/training (e.g., certifications, diplomas, transcripts, licenses, etc.) and list them below. This may require research on your behalf to contact former technical training and academic institutions to identify their specific procedures and any applicable fees for providing this service.

- _____
- _____
- _____
- _____
- _____
- _____

❖ *** Verify your military experience and training at: .https://www.dmdc.osd.mil/appj/vmet/index.jsp.. Assistance is available by meeting with an Education Counselor and instruction is available by attending the Transition GPS Core Curriculum training. Review the list of schools documented on the VMET site. If necessary, gather documentation and list below all military professional development schools you completed that are missing from the VMET site:

- _____
- _____
- _____
- _____

❖ Calculate American Council on Education (ACE) credits earned for military training (if applicable): .http://www.acenet.edu/Content/NavigationMenu/ProgramsServices/MilitaryPrograms/index.htm.

Number of ACE credits earned:_____

B. Verify Eligibility for Licensure and Credentialing.

❖ *** Crosswalk your military skill set to the corresponding civilian skills (MOC Crosswalk) at: .www.online.onetcenter.org/crosswalk.. Assistance is also available by meeting with an Education Counselor and instruction is available by attending the Transition GPS Core Curriculum.

Notes:

❖ *** Identify and document transferable credits earned through your military experience and training and verify your eligibility for licensure, certification and apprenticeship programs:

Department of Labor Workforce Credentials Information Resource Center	.www.careeronestop.org/CREDENTIALING/CredentialingHome.asp.
U.S. Army Credentialing Opportunities On-Line (COOL)	.https://www.cool.army.mil.
Army/American Council on Education Registry Transcript System (AARTS)	.http://aarts.army.mil/.
United Services Military Apprenticeship Program (USMAP)	.https://usmap.cnet.navy.mil/usmapss/static/usmap.jsp.
Defense Activity for Non-Traditional Education Support (DANTES)	.www.dantes.doded.mil/dantes_web/danteshome.asp.
Navy Credentialing Opportunities On-Line (COOL)	.https://www.cool.navy.mil.
Sailor/Marine American Council on Education Registry Transcript (SMART)	.https://smart.navy.mil/smart/signIn.do.
Community College of Air Force (CCAF)	.http://www.au.af.mil/au/ccaf/index.asp.
Air Force .Credentialing and Education Research Tool. (CERT)	.https://augateway.maxwell.af.mil/ccaf/certifications/programs/.

C. Identify career field(s) you are qualified to enter.

❖ Conduct personal research to explore and evaluate potential career field options.

Note: Any Guard or Reserve member facing employment difficulty prior to or after an active duty tour can contact Employer Support of the Guard and Reserve (.ESGR.org.) to learn their legal rights. ESGR will work to resolve conflicts or misunderstandings between the member and their employer.

DoD and VA Employment Search Tools & Job Listings	.https://h2h.jobs. .http://www.vetsuccess.gov/jobs.
Employment Hub	.www.turboTAP.org/portal/transition/resources/Employment_Hub.
State Job Boards	.www.careeronestop.org/jobsearch/cos_jobsites.aspx.
Public and Community Service Opportunities	.http://www.turbotap.org/portal/transition/lifestyles/Employment/Public_and_Community_Service_PACS_Registry_Program.
Department of Labor	.http://mynextmove.dol.gov/.
Teaching Opportunities/Troops to Teachers	.www.proudtoserveagain.com.

Federal Employment Opportunities	.http://www.usajobs.gov/. .www.go-defense.com.
Veterans Preference in Federal Employment	.http://www.opm.gov/staffingPortal/Vetguide.asp. .http://www.fedshirevets.gov/.
Office of Personnel Management (OPM) Special Hiring Authorities	.http://www.opm.gov/hr_practitioners/lawsregulations/appointingauthorities/index.asp.
Hiring Preference in Non-Appropriated Funds (NAF) Jobs	.http://www.turbotap.org/portal/transition/lifestyles/Employment/Federal_Jobs_Through_the_Non-Appropriated_Fund_and_the_Veterans_Readjustment_Act.
State Employment Agencies	.www.careeronestop.org/jobsearch/cos_jobsites.aspx.

- Refine your research to identify desired industries, careers, jobs and salaries. Consider jobs in the public and private sectors. Identify any prerequisites you would have to complete (e.g., education, training, certification, licensure, security clearance) before being fully qualified to seek employment in a chosen career field. Assistance is also available by meeting with a VA Career Counselor and instruction is available by attending Transition GPS.

Notes:

- Now that you identified potential careers, evaluate your ease to relocate and find new employment. Find where opportunities exist by researching employment websites such as .http://www.usajobs.gov/., and the Veterans Job Bank: .https://www.nationalresourcedirectory.gov/home/veterans_job_bank..

Notes:

- Now that you know where potential jobs exist, research those locations to determine if they meet your personal/family requirements. Explore state, city and county websites to evaluate demographics, school ratings, tax rates, cost of living, availability of housing, home prices, etc. Assistance is also available through your Transition Counselor and installation relocation assistance office and through the U.S. Census Bureau: .http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml..

Notes:

Section III. Determine Post-transition Career Path

A. Designate the career field you wish to pursue based on your personal, family and financial obligations and desires.

Desired Career Field: _____

Desired Relocation Destination: _____

B. Designate your transition career path.

❖ Select the transition career path you wish to pursue. Use the statements below each path to help you determine the appropriate transition career path.

☐ Employment (refer to ITP Block 2, Employment, Sec. IV; and Block 6, Milestones, Sec. VIII)
- I am qualified to seek immediate employment in my desired career field or I plan to explore future employment opportunities.

☐ Education (refer to ITP Block 3, Education, Sec. V; and Block 6, Milestones, Sec. VIII)
- I require additional education in my desired career field.

☐ Technical Training (refer to ITP Block 4, Technical Training, Sec. VI; and Block 6, Milestones, Sec. VIII)
- I require additional technical training in my desired career field.

☐ Entrepreneurship (refer to ITP Block 5, Entrepreneurship, Sec. VII; and Block 6, Milestones, Sec. VIII)
- I desire to start my own business.

APPENDIX D

INFORMED CONSENT

United States Command and General Staff College (CGSC)

Informed Consent Form for _____

This informed consent is for the following: Case Managers / Behavioral Health Providers / Physical Evaluation Board Liaison Officer (PEBLO) / Veteran. (Circle one)

Who I am inviting to participate in research concerning the Transition of Veterans diagnosed with Traumatic Brain Injury (TBI) and or Post Traumatic Stress Disorder (PTSD), titled "The Transitions of Veterans: The study of Veterans' diagnosed with Traumatic Brain Injury (TBI) and or Post Traumatic Stress Disorder (PTSD) and the Transition process into Civilian Life.

Researcher / Principle Interviewer: Mai Lee E. Eskelund, MAJ, U.S. Army
Name of Organization: Command General Staff College, Fort Leavenworth, Kansas

This Informed Consent Form will provide information concerning the study in order for you to make an informed decision about participation in this research.
It has two parts:

- Information Sheet (to share information about the study with you)
- Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction
I am conducting research on the transition process of Veterans' diagnosed with TBI/PTSD. I will provide you information on my research. Please stop me at any time as I brief you on the intent of my research and the consent form if you have questions.

Purpose of the Research

Major mental health conditions stemming from over 12 years of combat operations can result in issues such as Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD). Petska and Maclennan (2009) categorize the combination of mild TBI and PTSD as a signature injury for service members returning Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). U.S. Army soldiers who are officially diagnosed with TBI and PTSD may be referred to the Integrated Disability Evaluation System (IDES) to conduct a Medical Evaluation Board (MEB) and a Physical Evaluation Board (PEB). A soldier who is no longer fit for duty is then eligible for disability benefits and a preliminary VA disability rating will be assigned. Upon completion of the administrative evaluation boards, the Transition phase of the IDES process occurs. The Transition Phase allows a Soldier to out-process, retire, and or separate from the Army within a 90-day period and thus; the soldier is officially released or discharged from the

military. Making such a transition into civilian life can be a major life event. Soldiers who have not been diagnosed with TBI and PTSD find the transition stressful and overwhelming. It then becomes critical to examine what occurs after the IDES process and for the veteran with TBI and PTSD as he or she transitions into civilian life.

The primary research question is, "What factors facilitate positive behavioral health and a successful transition into civilian life for Soldiers who have completed a medical board due to Traumatic Brain Injury and Post Traumatic Stress Disorder and have been released from active duty service?"

Interviews
You are being invited to take part in this research because of your expertise and current work as a case manager/ Behavioral Health provider / PEBLO/ or Veteran who has similar criteria to the research being conducted and can thus provide and contribute to a better understanding about the transition process from the military to the civilian life.

This research will involve your participation in an interview format that will take about one but not last longer than two hours. Once complete, one or two follow up interviews may be needed to clarify a discussion point or question.

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. You may stop the interview at any time and may choose to not answer any of the questions presented.

Procedures and Confidentiality
I will personally conduct the interview. No one else will be present unless you would like someone else present. The information recoded is confidential and no one else except myself will access personal information documented during your interview. The entire interview will be taped but you will not be identified by name on tape. The tape will be kept to assist with transcription only. It will be stored in the Interviewer's storage locker. The tapes will be destroyed one year upon completion of this study.

Risks
This is qualitative research, which has minimal risk.
I will be asking your personal opinion in some of the questions. If you feel uncomfortable talking about any of the topics, you do not have to answer. There may be minimal risk that you share personal information, any personal information will only be taken will be to aid in the accuracy of this research or support the validity of the interview alone, and will not be distributed for the purpose of this research.

Benefits
There will be no direct benefit to you nor will be provide any incentive to take part in the research. Your participation is likely to help identify trends to assist with successful Transition for Veteran's who suffer from TBI and or PTSD for the future. You will not

Sharing the Results
The knowledge gained from this research and your interview will be shared with you upon request, to include a copy of this research. Nothing will be attributed to you by name unless specified or permitted by the interviewee directly.

Who to Contact
If you have questions, concerns, or need more information, please contact the following:
Mai Lee Eskelund, Major, United States Army. Cell: 512-663-7384 or mai_leee@hotmail.com.

This proposal has been reviewed and approved by Dr. Maria Clark, whose task it is to make sure that research participants are protected from harm. If you have concerns regarding this research or its conduct please contact Dr. Clark at maria.l.clark.civ@mail.mil or 913-684-7332.

Part II: Certificate of Consent (This section is mandatory)

I agree to voluntarily enter into this study. I have read the informed consent form, and it was explained to me in a language which I use and understand. I have had the opportunity to ask questions and have received satisfactory answers. I understand that I can withdraw at any time. A copy of this signed Informed Consent Form has been given to me.

Print Name of Participant_____

Signature of Participant _____

Date _____
Day/month/year

A copy of this ICF has been provided to the participant.
Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____
Day/month/year

APPENDIX E

VA CASE MANAGER FUNCTIONAL DESCRIPTION

SOCIAL WORKER OEF/OIF/OND CASE MANAGER
GS-185-11

1. GENERAL DESCRIPTION

Incumbent is a professional social worker whose duties and responsibilities relate to the care management of severely ill and/or injured Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) service members and veterans. The incumbent must use a high level of skill in assessing and treating the complicated psychosocial problems of OEF/OIF service members and veterans as they transition to Department of Veterans Affairs (VA) care.

The incumbent assists OEF/OIF/OND service members and veterans in coping with acute illness, chronic illness, combat stress, residuals of traumatic brain injury (TBI), community adjustment, addictions, and other health and mental health problems. The incumbent social worker case manager addresses home care needs, homelessness, and transition across levels and sites of care.

Social Work case management practice includes psychosocial assessment and treatment that is focused on helping OEF/OIF service members and veterans and their families maximize rehabilitation and treatment potential and achieve more adequate, satisfying, and productive emotional and social functioning.

2. FUNCTIONS OF POSITION

The incumbent social work case manager under supervision:

- Works with OEF/OIF service members and veterans and families experiencing a wide range of complicated mental, emotional, behavioral, physical, psychosocial, and environmental problems
- Demonstrates the ability to assess the psychosocial functioning and needs of patients and their family members and to formulate and implement a treatment plan, identifying the patient's challenges, strengths, weaknesses, coping skills and assistance needed, in collaboration with the patient, family and interdisciplinary treatment team
- Demonstrates the ability to independently provide counseling and/or psychotherapy services to individuals, groups and families
- Demonstrates experience and knowledge in the use of medical and mental health diagnoses, disabilities and treatment procedures, including acute, chronic, and traumatic illnesses/injuries
- Conducts psychosocial assessments and collaborates with interdisciplinary team members to develop a care management plan and psychosocial interventions
- Evaluates the need for mental health services and makes appropriate referrals for individual, group, marital, and family treatment services
- Is sensitive to the ethnic and cultural diversity and age-specific challenges of the OEF/OIF population and adjusts intervention and treatment plans as appropriate
- Participates in developing, planning, implementing and evaluating the interdisciplinary treatment plan, including provision of care management services

- Coordinates care with interdisciplinary teams to promote continuity for OEF/OIF service members and veterans and their families
- Develops and uses appropriate community resources
- Serves as an advocate for OEF/OIF service members and veterans and their families, helping them access needed VHA services and in the community
- Assists OEF/OIF service members and veterans and their families with advance directives and applications for home care and extended care services
- Participates in the orientation, training, and teaching of social work students and staff
- Documents patient's progress by creating a progress note for each encounter
- Provides consultation as requested to inpatient units and outpatient clinics
- Keeps supervisor apprised of problems and recommended solutions to problems encountered in the incumbent's area of responsibility
- Is responsible for furthering own professional growth through education, appropriate to area of assignment, and providing coverage during social worker absences
- Maintains a level of productivity and quality consistent with Social Work standards and the complexity of the assignment
- Participates in interdisciplinary team meetings, appropriate facility meetings, and Social Work meetings
- Shares knowledge and experiences gained from own clinical practice and education relevant to the field of Social work
- Complies with Equal Employment Opportunity (EEO) Program and safety policies and procedures
- Supports the mission, policies, and procedures of VA, the Veterans Health Administration (VHA), the appropriate Veterans Integrated Service Network (VISN), and the facility.

3. SUPERVISORY CONTROLS

The incumbent reports programmatically to the facility OEF/OIF Program Manager, who assigns severely ill and/or injured OEF/OIF veterans to the social worker case manager. Clinically reports to the OEF/OIF/OND Program Manager performs administrative matters and seeks consultation in unusual and/or complicated situations. Keeps the Program Manager informed about concerns and/or changes.

4. QUALIFICATIONS

Incumbent meets the qualification standard for the GS-11 Social Worker as defined in VA Handbook 5005, Part II Appendix G-39, Social Worker Qualification Standard GS-185 Veterans Health Administration.

5. CUSTOMER SERVICE REQUIREMENTS

Incumbent's personal contacts in this position are with active duty service members, veterans, and their families; other facility clinical and administrative staff; staff at Military Treatment Facilities, TRICARE, and National Guard and Reserve units; community agencies; students in training; and representatives of local, state, and Federal institutions.

The incumbent must be skillful and tactful in communicating with people who may be physically or mentally ill, uncooperative, fearful, emotionally distraught, and occasionally dangerous. Incumbent meets the needs of customers while supporting VA missions. Consistently communicates and treats customers (Veterans, their representatives, visitors, and all VA staff) in a courteous, tactful, and respectful manner.

Incumbent provides the customer with consistent information according to established policies and procedures. Handles conflict and problems in dealing with the consumer constructively and appropriately.

6. AGE, DEVELOPMENT, AND CULTURAL NEEDS OF PATIENTS REQUIREMENTS
Incumbent provides age-specific care that is appropriate to the cognitive, emotional, cultural, and chronological maturation needs of the patient. Demonstrates knowledge of changes associated with aging and principles of growth and development relevant to the adult and geriatric age groups; ability to assess and interpret data about the patient's status; and ability to identify age-specific needs and provide the appropriate care based upon the age related factors.

Takes into consideration age-related differences of the various veteran populations served:

- Young adulthood (20-40). Persons in general have normal physical functions and lifestyles. Person establishes relationships with significant others and is competent to relate to others.
- Middle age (40-65). Persons may have physical problems and may have changes in lifestyles because children have left home or change in occupation goals.
- Older adulthood (65-75). Persons may be adapting to retirement and changing physical.
- Middle old (75-85). Persons may be adapting to decline in speed of movement, reaction time, and sensory abilities. Also, persons may have increasing dependence on others.
- Old (85 and over). Increasing physical problems may develop.

7. COMPUTER SECURITY REQUIREMENTS
Incumbent protects printed and electronic files containing sensitive data in accordance with the provisions of the Privacy Act of 1974 and other applicable laws, Federal regulations, VA statutes and policy, and VHA policy. Also protects the data from unauthorized release or from loss, alteration, or unauthorized deletion. Must follow the applicable regulations and instructions regarding access to computerized files, release of access codes, etc.

Incumbent uses word processing software to execute several office automation functions such as storing and retrieving electronic documents and files; activating printers; inserting and deleting text, formatting letters, reports, and memoranda; and transmitting and receiving e-mail. Uses the Veterans Health Information and Technology Architecture (VistA) to access information in the Medical Center Computer System.

_____ _____
Supervisor Signature Date

_____ _____
Employee Signature Date

APPENDIX F

J1D–PEBLO INTERVIEW–PHYSICAL EVALUATION

BOARD LIASION OFFICER

INTERVIEWER: What is the current process upon completing the MEB and the transition process thereafter.

J1D–INTERVIEWEE: Once a PEB is completed, the soldier receives their ratings and the transition points starts. Soldier agrees to the finding and the Secretary of the Army concurs and signs paperwork. NLT date is assigned and the transition date is 90 day from when the Physical Disability Agency gets the packet, agrees, signs. The 90 days is what the soldier has to transition from active duty to civilian. Part of PEBLO responsibility is to sit down with the Soldier and inform them of the NLT date and review future options (education, job ect) which dictates the date of transition. This date can be sooner. ACAP is complete.

INTERVIEWER: ACAP is complete at this time? And when is it done by?

J1D–INTERVIEWEE: Yes. PEB Phase. In the MEB phase they have the initial counseling, the first 30 days of process. Then TAP and DTAP once they are found unfit by the PEB. Work with ACAP to ensure they get the soldiers in. ACAP tracks the soldiers. As a small post we are able to work well with ACAP and get into a schedule. Once they get the NLT date, we go over that with the soldier. If an earlier transition is possible, we aid in that (inform command, prepare them through ACAP, and execute quickly).

INTERVIEWER: So you will shorten the 90 day timeline, but will you extend it?

J1D–INTERVIEWEE: It can only be extended with the request to the Physical Disability Agency with an O6 signature to endorse and why/ the soldier must provide substantial reason.

INTERVIEWER: What if a soldier is unable to transition because suffering from X,Y,Z.

J1D–INTERVIEWEE: There are medical extensions that can be granted and they are based on a case by case basis.

IDES is very individually based. Every case is totally different. Most PTSD and TBI, we ensure that we do a smooth handover with the VA. Making sure VA has soldier information because IDES is a dual process with the VA, that is what it was designed to do, and we make sure we do that. We also ensure that the service member has the interview with the MSE and ensure all the forms are correct, that finance and paperwork is correct, and transition occurs. The next step that we do here is notify the AG that we have a soldier coming up for TRANSBOK. TRANSBOK is the transition system that AG uses for orders, that is done by HRC. We notify AG that a soldier is coming up for separation.

INTERVIEWER: The ACAP, TAP, DTAP is considered pre-transition programs, to help them think of future possibilities. That is completely separate from the handover into the VA system. In IDES is created to do one set of exams for DoD and VA.

J1D–INTERVIEWEE: Confirmed.

INTERVIEWER: There have been a few other articles, saying that separation time is given 12 months out of the military. It was an EXORD from DoD in 2011. It

seems like the 90 day transition time given for the IDES soldier is a shorter time than the 12 months given to other soldiers who get 12.

J1D–INTERVIEWEE: Remember with IDES, the soldier did not decide to start the process; it was started for them. We use to have it that the soldier starts ACAPing once in the IDES system; we found that they do not retain what ACAP they went to after the year is up. What would benefit the soldier better. Once they are found unfit, it is actually at that point that they face the reality of separation.

A plus to the transition of the medical board is the PEBLO because they walk a soldier through that the regular soldier does not get. We get more positive feedback from soldiers who receive ACAP information at a point were they can receive and retain it.

INTERVIEWER: At what time point is that, where the soldier is able to retain what they learn?

J1D–INTERVIEWEE: Less than 6 months, usually around the point of the PEB. Because if you do it at the beginning of the year, they are not going to retain it. And they may be dealing with issues of retaining. In the last 90 days, our sister services are using, a program that allows an IDES soldier to internship with interagency programs (i.e. forestry, or local programs) to see if they can transition into civilian life. It has to be command supported at the unit level. One of our biggest things is helping the soldier and keeping the command informed of the phases, what is occurring, what the soldier and the unit must take care of.

INTERVIEWER: What level do you reach down to?

J1D–INTERVIEWEE: Company command level CO and 1SG. We can get the support at the command level.

INTERVIEWER: What happens if the command will not allow them to ACAP or separate due to OPTEMPO?

J1D–INTERVIEWEE: IDES is mandatory. Commands are informed. Soldiers cannot schedule or cancel appointments. The soldier will come talk with us, but we reach out to the command and the command needs to be prepared to have that soldier gone and prepare accordingly.

INTERVIEWER: You work one on one and become their confidant. To recap: through the IDES, they have an initial counseling in the MEB phase and determine if they are retained for duty.

J1D–INTERVIEWEE: MEB only discuss if they fail or meet the retention standards for AR 40-501 (medical condition that prevents from performing their duty) and the PEB is if they are fit or unfit for duty. The PEB makes a determination if the medical things hinder the performance of the soldier.

INTERVIEWER: within that initial phase they are able to go to ACAP for their initial counseling. Once the PEB is determined?

J1D–INTERVIEWEE: Than ACAP will schedule the full 5 day program with ACAP. That is our point where ACAP and transitional phase is started and allows the soldier to go through ACAP. They may make a smoother transition when they attend ACAP.

INTERVIEWER: That mental change to prepare them has to help?

J1D–INTERVIEWEE: yes, correct.

INTERVIEWER: Add the PTSD and TBI to the process. During both IDES boards, MEB and PEB is there continued counseling?

J1D–INTERVIEWEE: Yes. We have an Annex that says we will keep the service member in counseling providing the counseling with command and member for BH, stay in counseling throughout the process. They do not stop once they are in IDES.

INTERVIEWER: Is that transition made from Behavioral Health to VA?

J1D–INTERVIEWEE: That answer has to come from Behavioral Health.VA has the information on the service members and completed medical exams and have established exams for PTSD/TBI are with the VA.

INTERVIEWER: When you talk about transition with the VA, it means making sure the VA has all the proper documentation. Do we do a one on one hand over from the service member to the VA?

J1D–INTERVIEWEE: No not really, the last situation we had had the nurse case manager with a local soldier, the hand off is easier because it is local. Unknown between case managers.

INTERVIEWER: The person outside the local area, PEBLO ensures that they are within the VA system, and properly input documents so that the VA picks them up?

J1D–INTERVIEWEE: Yes but we steadily counsel them that they contact the VA. If they buy into TRICARE you have the right to go to the nearest MTF for care.

INTERVIEWER: Is it a two way responsibility for both the soldier and the VA to make contact with each other?

J1D–INTERVIEWEE: Correct. There is a different program when a soldier goes on Temporary Disability Retirement List TDRL. These service members will return back for an exam in 12-18 months because their conditions were not stable. They are considered retired, temporarily, until they know that their conditions are stable, which is

decided by the PEB. That Soldier is given a OIF/OEF/OND Case Manager. If they meet a specific percentage and have PTSD and combat injuries. The Case Manager will contact them. We inform the service member to ensure they continue their counseling. Get with the VA or the Medical Treatment Facility.

The PEBLO, as the transition POC gives, added encouragement. Together with the soldier for about a year from start to finish.

INTERVIEWER: Transition process, what things can make the process easier for a soldier with PTSD, TBI?

J1D–INTERVIEWEE: The easiest is 1) The command support to aid in the transition, and understanding in the appointments and the soldier's situation in order to properly attend ACAP and transitional events because these events still must be support and approved by the command. 2) The communication with the transition point at AG, because it reviews what they need to transition, what paperwork they may need, to assist in a smooth transition. 3) The VA LNO, the person that ensures that there is no, to little, financial hardships. All paperwork DD214, exit, enter interviews with the VA. You do not want to deal with financial support.

INTERVIEWER: Is that about the admin paperwork is processed and taken care of so it will not be an issue?

J1D–INTERVIEWEE: Yes, but there is more than that. It is also that everyone is leaving to different areas. That is a part of the checklist to check that the soldier is no longer active on X date, and benefits roll over with no issue. Each situation is different and every soldier has to have an exit interview.

INTERVIEWER: Are there anything specific to BH issues or does this pertain to everyone?

J1D–INTERVIEWEE: Everyone in a sense, but with a BH, we coordinate with nurse case manager, to stay informed on the status on the solider. Stress levels do rise. Certain aspects of the IDES process, we have no control over, like waiting on the ratings. Special circumstances, the MTF commander may ask for an expedite of the ratings due to the condition. It is up to the PEB to grant the expedited paperwork.

INTERVIEWER: What are the major aspects that can impede the process?

J1D–INTERVIEWEE: Appointments. If soldiers are not able to go to ACAP, which is now mandatory. If the service member doesn't get the proper counseling to feel like they have support.

INTERVIEWER: The transition process is stressful for someone without a medical diagnosis. Add PTSD or TBI to the picture, it can make the transition more difficult.

J1D–INTERVIEWEE: We tell the service members' to bring their families because support is crucial, and this process affects them both. As a PEBLO, I try and provide single (or not) support and work with their situation and try and incorporate other family members, mom, parents, and spouses. I try and help them not make a hasty decision. Provide them time to process the circumstances. I always ask them what is there plan. I'm going to open a tattoo shop, then let's figure out what that looks like and how we are going to get you to that point. If that is what is in your heart, than who am I to tell you no, you served my country.

INTERVIEWER: Do you walk them through the process?

J1D–INTERVIEWEE: I remind them what they learned in TAP or ACAP and go over the options that they have: small business loan, school, GI bill, VA education. Lets talk through it.

INTERVIEWER: What tends have you seen on good transitions?

J1D–INTERVIEWEE: I love it when I see my soldiers come in with a plan. They know what they are going to do, they have to have it written and organized. It helps them visualize.

INTERVIEWER: What about the person suffering from depression and PTSD, TBI, who may forget or not be engaged, how do you deal with them?

J1D–INTERVIEWEE: Where is your book–I know that they have a mechanism to track. And we will go over verbally, but we will then reinforce the process.

INTERVIEWER: Even though the soldier may be suffering through, you try and provide the information to them so they have it when they are ready to process it?

J1D–INTERVIEWEE: Yes, correct because given all the information at one time, they can't take it in. We take measures to track it, where is the book, we go over the process, and reinforcement of the process and where they are in the process.

INTERVIEWER: The process, are there strengths, and what have you seen?

J1D–INTERVIEWEE: Of Transition. We are small and unique. Our strength is that we are able to reach out to individual and groups (ACAP, VA, AG . . .) in order to assist the soldier to complete and aid in the transition. Work well within the machine. ACAP and AG are the two major entities of the process along with the VA LNO. And I can physically take them down to each.

INTERVIEWER: As the process, are there areas of weakness that you've seen that may need to be addressed?

J1D–INTERVIEWEE: The compensation for the soldiers when they transition. Because we do not know when the soldier receives their benefits. We really do not know, unless soldiers call back with an issue. Suppose to get their benefits within 30 days. There have been issues, when they did not get their financial portion completed. Having the financial be 30 more days. It happens more out of state, and we can try and help get the paperwork needed. It has happened. The bigger picture is with the VA, who then is responsible for paying from the VA, we do not want the soldier to worry about this, but the financial support is not there. They are gone from DoD responsibility.

INTERVIEWER: In the end, in Behavioral Health and everyone in the process, we are all advocating for the soldiers, What is the one thing that may help them get through the stress to keep focused on the positive?

J1D–INTERVIEWEE: I think the only way they can do that is when they come to the realization that the active duty is now over. I think that behavioral health can assist them that they are no longer in the army, to show what their new path can look like for their future. Even if you retire, the process is hard, and you want the positive transition to be "I have something else" to look forward to. Even if the goal changes, to know that you have a plan and you want to be effective at.

INTERVIEWER: The people that help with the transition process are advocating for the transition into a new life?

J1D–INTERVIEWEE: Yes. I'd absolutely agree to that.

INTERVIEWER: Anything else you'd like to add?

J1D–INTERVIEWEE: We are now being given the opportunity to have other services come in assist the service members where they can be removed from the environment that may be the cause of the problem. It helps them transition. From working supply for 40 hrs a week, I now have 25 that I work with the animals. It provides different opportunities to work with other, different people, and professions. And it also allows them to see if the soldier can make that change or transition or work in another environment. It gives them an opportunity. I'd recommend it for future transition programs, as long as the command can support it, it does help the soldier transition. That type of support and new offers is a good transition, especially when they are being found unfit for military service. It is good for the soldier to see what they can do next.

APPENDIX G

F2V-INTERVIEW–VA CASE

MANAGER SUPERVISOR

INTERVIEWER: Lead us into the process, when does VA begin seeing a soldier out of the military and into the VA.

F2V-INTERVIEWEE: We have LNO at the MTF, and we get a lot of referrals from them. They contact me by e-mail and scan and attach the Medical packet–NARSUM–and recommend VA rating. The case manager at the military post will then request to the LNO with that information. And the VA LNO will contact the VA that the service member will be discharged near.

INTERVIEWER: Once it is known that the service member will be discharged, then they get in contact with you?

F2V-INTERVIEWEE: It depends. We get referrals the day before terminal leave, the day after they left for Terminal leave, or before they get their orders cut. It varies widely.

INTERVIEWER: By regulation or doctrine, at what point and time are you suppose to get that information?

F2V-INTERVIEWEE: We are suppose to get it before they go on terminal leave. Once they go on leave, they are scattered. Sometimes they answer their cell phone, sometimes, they don't. We don't know where they will be heading too and that can be a big mess.

INTERVIEWER: And once you are aware of a soldier, what is the process now that they are identified?

F2V-INTERVIEWEE: We contact that soldier and ask them to verify that they are staying in the area, basic information on where they are living, what their discharge plans are, including financial situation and talk about what kind of appointment they need at our VA. Then we schedule at least a new patient, primary care appointment and a mental health assessment appointment, and if they'd like a dental, they can usually get a free one within the first six months.

INTERVIEWER: Is the mental health assessment mandatory for everyone or only those with PTSD?

F2V-INTERVIEWEE: It is not mandatory for anybody, it is completely up to them whether they want a follow up with VA. The vast majority of them do. Both for medication assistance and therapy that they want to continue.

INTERVIEWER: So if they have a known diagnosis and they are already within the VA, but they don't want the assessment, can they stop treatment on their own?

F2V-INTERVIEWEE: Yes, they are free citizens, once they discharge, they are out of service.

INTERVIEWER: And what does the transition look like going from DoD therapy into the VA counseling?

F2V-INTERVIEWEE: We have a junction city clinic. And we have a lot of patients who live in that area. We would try and link them up for therapy. They do have to come into the main clinic for their initial health assessment, hopefully with a psychiatrist to get their meds provided within the assessment. If it is completed with a non-psychiatrist (social worker or psychologist, the patient has to return to get a

prescription for their meds and it may be a barrier and cause other issues. We also have a vet center that can provide therapy as well.

INTERVIEWER: Do they still have to go through an initial assessment?

F2V-INTERVIEWEE: Not necessarily, if they want treatment or therapy through the vet clinic, they can do that. But they will not have medication providers.

INTERVIEWER: Do you get a lot of folks from out of state? How does that handover work with DoD?

F2V-INTERVIEWEE: It is email. VA LNO across the nation, if they know that a service member is discharging in our area, they have to call me and communicate with me via phone or email. And I have to acknowledge that receipt of that service member. And the medboard packet will be scanned or faxed. This mandatory and a two way process. We then have a week, we generally give two weeks, before we schedule appointments in the VA, so that the LNO can close out the soldier's packet.

INTERVIEWER: After initial contact, you offer initial service, what happens next?

F2V-INTERVIEWEE: They then qualify for case management services that we provide. We have a case management tracking system, that we can enter information into if we have to keep contact with the veteran, quarterly, semi-annually ect . . . to help keep case management organized which is tracked nationally. If calls are not made within the month, than we are reported to the central office.

INTERVIEWER: Your location is large, about how many cases does each case manager get? Is this mandated?

F2V-INTERVIEWEE: No, but we have about a maximum of 35. But I am not sure about that number.

INTERVIEWER: And then the soldier gets into other services available?

F2V-INTERVIEWEE: Any of the specialty clinic, they first must get in with their primary care provider before they get into a specialty clinic like neurology, or physical therapy.

INTERVIEWER: On initial contact, how long does it take to get an appointment with their primary care provider?

F2V-INTERVIEWEE: If we got a late referral and the person was discharging today, we would have about a 6 week wait before we could get them into the primary health care provider.

INTERVIEWER: Do they have to see the primary care provide before they do a behavioral health assessment?

F2V-INTERVIEWEE: No. Triage and mental health is available. This option some may have to do if they are running out of their medications. If they are from Ft. Riley, then we can view those, cause they are in our system.

INTERVIEWER: If they completed IDES, how are they not in the VA system? Do individuals have to be transferred into the Topeka system?

F2V-INTERVIEWEE: The IDES examiners at Riley are VA employees and they use the VA computer system to enter their work. If at a remote location, then we are suppose to see it through the remote data, and pull the information from other VA sites. From a remote site from that actual VA, which all the IDES exams are, because they are

at the MTF not a VA system, we should have everything on paper and medical records are scanned.

INTERVIEWER: 6 week max wait if you get the paperwork today? But the walk in a triage is there if they need a temporary solution.

F2V-INTERVIEWEE: Yes. We have an urgent care center. Leavenworth has a fully functional emergency room, and both have walk in capabilities as well.

F2V-INTERVIEWEE: Clarification, that the 6 week average wait time for a new patient appointment is for someone we get and they are out. Normally, we get them in plenty of time and we schedule the first appoint the day after they discharge officially.

INTERVIEWER: Who has to wait 6 weeks?

F2V-INTERVIEWEE: If a person is in the MED board process and they don't have terminal leave, and orders get cut and the case manager doesn't get the VA the packet OR the soldier is getting discharged the next day. We normally get plenty of time to make those appointment.

INTERVIEWER: Does the DoD VA LNO call you to make those appointments?

F2V-INTERVIEWEE: Correct, call or email and then attach a scan document, MTF referral, PEB MEB findings, VA IDES exam, and NARSUM. From that we contact the service member and make sure their discharge date and when they want their appointment. Some people have terminal leave, some referrals are late, but most of the time, we have time to set up appointments after their discharge.

INTERVIEWER: Pre-planning and pre-coordination mitigates the time issue. Is there a policy that states when you SHOULD get that paperwork?

F2V-INTERVIEWEE: No cause it is all over the place. As far as the orders goes, particularly on Fort Riley, it could be if that person is on vacation or something happens, than you can have a slew of them coming through in a week. The DoD case managers will do a referral to a VA LNO who will do a referral to the VA.

INTERVIEWER: Once the soldier is released, the next day they can come in the VA System?

F2V-INTERVIEWEE: Yes, once they leave on their discharge date. This gets complicated with terminal leave, and they still need to be using the military for their health care need.

INTERVIEWER: During Terminal leave, do they not fall under VA?

F2V-INTERVIEWEE: Correct. Unless there is a TRICARE authorizations that a military case manager is suppose to assist with. For instance, if they are moving is someone needs specialty care or they are moving away from a military base, they can do a TRICARE authorization, then VA or a community provider can see them. But they will still not be within the VA System, but they do not need to re-establish themselves upon completion of their terminal leave. The vast majority of our referrals are from Riley and the VA is doing the referrals in the system. It is all local, and makes it easy.

A problem that we do have, if we cannot lay hands on them until the day that they are discharged, if they need specialty care, unless there is a TRICARE authorization, we cannot set up consults for specialty care clinics such as neurology, physical therapy it has to come from the primary care provider.

INTERVIEWER: How long is the wait from the primary care provider to the specialty clinic?

F2V-INTERVIEWEE: It is all over the place. It can be a week or it could be two months. Something non critical wait time is running 3 months out for a regular clinic appointment. If someone runs out of medication, due to timing and scheduling, we have to tell them to come in for Triage, particularly with Behavioral Health. This is typical, it is a lot of wait time and depending on how they are doing, sitting in a crowded waiting room, in a strange place can be nerve racking and not knowing when you will be seen. If they have PTSD they feel hemmed in. We have a lot of guys waiting in the hallway of BH because they cannot tolerate sitting in the waiting room.

INTERVIEWER: What if they have a known TBI and info is in their file, can they make an appointment simultaneously with neurology as they do with the primary care provider?

F2V-INTERVIEWEE: No. Generally, honestly, there is a new patient TBI screening that has to be done. What the OIF/OEF program tries to do is contact all new enrollees. If we can screen them over the phone, than it automatically goes to a consult. We have seen so few, even moderate, much less severe TBI, it does not happen as much. We have tons of people with mild TBI. Normalization needs to occur, after a TBI follow up, the conclusion is that the symptoms are better explained by their PTSD and the recommendation is for the follow up with PTSD treatment. There is not a lot you can do with mTBI. The question is how many mTBI you have to identify cumulative damage, and what really can we do for them. That is an ongoing situation and reality.

INTERVIEWER: I am focusing on mTBI, and there is a longer process of IDES, by the time the patient is seen, the effects of the TBI may not be an issue, is that correct?

F2V-INTERVIEWEE: Yes. Either by the time they get out regularly or med boarded take up to a year, it is not like they are coming back directly from combat, often times there is a lot more time. By the time we see them, the TBI are so remote, that generally it is the PTSD that we are seeing. For the moderate and severe, I can recall maybe one maybe two TBI. One guy came from Indiana, and was being out processed and he and his wife were moving to a town south of us, so we had to set up remote services. This was a challenge, but he had his rehab done ahead of time before he came here.

INTERVIEWER: Are there any other major aspects or parts of this process that, in your opinion, could be stronger, or needs to be evaluated to make this process better?

F2V-INTERVIEWEE: I can see one coming. We have only been peripherally involved in it. Our case management is changing. The Lead Coordinator is being rolled out world wide, but there is a long checklist of areas of a person's life, areas with problems may arise, literally pages long. The checklist is suppose to start with DoD Case managers and it should be handed off to the VA that the soldier is going to. DoD is not doing it, so the VA is having to start from scratch with a very long checklist, with a person we are just getting to know who just walked in the door. And we are suppose to have an intensive treatment plan of with a team to aid. DoD is not starting it, VA is having to pick it up. It is not ideal. This process has already started for about a year. There are certain sites, Reed, Belvoir, and two other sites that are doing this. It is understood that every soldier is to have a lead coordinator on the VA side to receive the checklist and get the players lined up and ready to go. It is not happening and we are stuck with trying to put this together.

INTERVIEWER: If DoD was to put this together on their side, do you think this plan would assist in any way?

F2V-INTERVIEWEE: Yes. With complicated case this would be good. With smaller cases, then it is limited needed, but we see people coming out with 8-10 service connected conditions. Muscular conditions with the back and the knees and they need specialties or follow up care and it would give us a big leg up.

INTERVIEWER: Are there any other aspects that you would want improved?

F2V-INTERVIEWEE: Realistically, I don't think that they can be. With the number of people that are involved in the process, there are going to be late referrals and last minute issues. I have not experienced anyone willfully not doing their job. It is just a matter that it is such a huge system Just because it is the nature of the beast, you wait forever to get the finding adjudicated and done and then all of a sudden here it is. You hear from guys that they have been waiting over a year, a year plus, then all of a sudden they get their orders, and I'm out. I don't see anyway that DoD can change.

INTERVIEWER: Are there any major aspects that may impede behavioral health healing?

F2V-INTERVIEWEE: Yes, just the waiting. And then it depends on the care that you are getting on the base. I use to work on the acute psych unit, and we would get active duty soldiers, in the process of going through IDES, who were getting treated like crap by their command. You're faking it. What good are you? You are refusing to do anything.–some was legitimate, and some was disorders. And that affects the soldier and adds to their stress. And even if they aren't hospitalized, there is so much waiting. Some people don't mind it cause it helps them transition and move into thinking what the next

step is. But it is the unknown of the disability and compensation. What am I going to do if I can't make money.

INTERVIEWER: Is there anyway to mitigate the wait?

F2V-INTERVIEWEE: Hire more people. It is the base of the machine. They have multiple problems. Behavioral health, back, neurological, ortho doctor, auditory, they can be extensive for one discharge process. And then in the VA someone has to review all documentation for DoD and VA. It takes some time.

INTERVIEWER: Do you feel that you are undermanned?

F2V-INTERVIEWEE: If I had at least one more person, we could do a lot more than just case management or phone calls. We always have people who go into crisis. We are trying to start doing groups, working with the care givers. We'd love to do something with the families and kids. But just the time, doesn't allow it. Our mental health clinic is so overloaded, that the availability of treatment is needed.

INTERVIEWER: Is there anything that you believe is happening well?

F2V-INTERVIEWEE: I believe that for a majority of the time, we are getting referrals from DoD in a timely manner and we can Contact the service member. Every once in a while we are not able to contact them, if they get a different cell phone number, or they don't call us back. They have the right to refuse service, which is hard to explain to the VA command. We are setting up the appointments and explaining the triage options, and case managers are getting in and helping the process along and getting the pay started and helping them be prepared for financial issues. The Bumps in the road take up more time. 10 percent takes up most of your time, because most process works well. This goes for the veteran cases as well. They transition fine, have good support, base of

friends, church, doing alright, with the treatment and assistance and services. Just a little tweaking here and there if something does go wrong.

INTERVIEWER: I don't think we hear about the good cases.–always the worst case scenarios. Are those the minority through the system?

F2V-INTERVIEWEE: Yes, I do. Even considering nation wide, most are lucky because a system like LA or NY they are running out so long for appointments, it is crazy, and they just don't have the capacity.

INTERVIEWER: What can Soldier do to assist in the transition process?

F2V-INTERVIEWEE: If they would just Listen. At the beginning of the Medboard process, people sit down and tell them about the process, benefits, financial planning and Logistical things. And it goes in one ear and out the other. The VA pay, doesn't' start for up to four months. PEBLOS are swearing they are telling the soldiers, but the Soldiers not hearing it. Unfortunately we see soldiers who have not been managing their money well, have no money, with no place to live, and ask "what do you mean we won't be getting a check for 4-6 months." Sometimes it is what they have been told.

INTERVIEWER: This sounds like an issue in planning.

F2V-INTERVIEWEE: Correct. Part of it may be young. It may be denial, or behavioral health issue. I think that is the biggest. And then not being in contact with the VA or the LNO once they do get the packet. We have several instances we call and call, VM message left, or they are calling back and then they are out and do not have anything and run into problems.

INTERVIEWER: How important is a support base to the transition process.

F2V-INTERVIEWEE: It is Critical; absolutely Essential. If they don't have a spouse, or parents, or a good group of friends, a place they feel like they belong and be steady during the whole process and after their military life.

INTERVIEWER: Are there any other components similar to that that can help or is that the pinnacle?

F2V-INTERVIEWEE: that is the pinnacle , because no matter what medical or mental health condition they are in, that is not going to change. The only thing that can help mitigate the perception of pain, loneliness and depression is mitigated by a good support system.

INTERVIEWER: Anything else you would like to add or have people understand about the transition process?

F2V-INTERVIEWEE: Something we are keeping a close eye on, with the TBI, with a moderate or severe, then it is obvious. There are concrete protocols to treat and deal with. It is the mild ones that accumulate over 2, 3, 4 tours, or motorcycle accidents, that is what I think is critical to learn more about, and what impact does it have and what can we learn about it? Repeated TBI, I think that Washington is trying to do stuff about it and understand how the brain works and map the issues, and develop helpful protocols.

APPENDIX H

C3V-INTERNIEW–VA CASE MANAGER

INTERVIEWER: Can you tell me the process for transition that occurs?

C3V–INTERVIEWEE: We have two VA LNOs, at Fort Riley, what they do is they will meet with the person in transition and refer the soldier to the VA. Provide the whole packet, military treatment facility referral packet. 2-3 pages of basic information, dates of services, for OIF/ OEF, and the reason for referral/combat injury. Then it comes to use and we have a timeline and we have to call within 7 days. We have to set up an appointment, even if in TDRL status. We have a bunch that are getting out in June or July, and I call to set up appt, even if not Veteran, load in system as active duty, schedule appoint, talk to them on the phone, answer questions, have referral for health care. They are not in the system, they are only in the computer, but not in the system as a Veteran. They need to provide their paperwork, DD214. That is what happens from Fort Riley, or other locations. That packet includes the PEB form, the VA proposal, and medial records, which is scanned in.

VA LNO not at Leavenworth, [note that this is not what was said by the PEBLO] not at every location, I think it depends on the size, but not everyone has a VA LNO. A lot referrals are by accident from Fort Leavenworth. I Don't know that the Vet is coming, or they enroll like a regular patient, walk in come up on the new patient list. We make contact with them that way, within 30 days. When I'm talking to them, I hear that they went through a medboard process. I had a guy who came in and went through the medboard process and he needed help. Some people don't need case or care management.

But there are people that are already struggling with their mental health. And we took care of this man.

INTERVIEWER: Was he in the VA system?

C3V–INTERVIEWEE: He was, because he did his stuff here at the VA. The documentation was the C&P exams.

INTERVIEWER: Under Riley's circumstances, the VA LNO is the in between who assist in the transition from DoD to the VA.

C3V–INTERVIEWEE: Yes. We've talked to the PEBLO to try and make good connections. But it is not the PEBLO's job to be the LNO, but the BH clinic will keep in touch and communicate between. The counselors will contact me and help in the transition.

INTERVIEWER: What is the system between Leavenworth DoD and VA?

C3V–INTERVIEWEE: The only referral contact is with Behavioral Health and me (case manager). The people in flux in the DoD IDES system, in medboard process, or preparing to transition out, we do try and get them started on the process in the VA. They were short staffed, so we were trying to work together to get soldiers served and get them in the system for mental health services so that they wouldn't have to change it midstream as they transition out. There is a Sharing agreement, mainly in mental health area. For instance in group, if someone wants to come to the PTSD support group, we have some people in uniform that come, we see that consistently. And then psychiatry service is by availability, and that is a referral process. As long as there is space (or the wait list is not full) is available then we will take the soldier. But we will not make the

veteran wait for services. I mostly see psychiatry and group being served through the sharing agreement.

INTERVIEWER: Are there any rules or guiding regulations that you have to follow for soldiers who get out of DoD into VA? Transitioning from DoD to VA are there standards for that transition?

C3V–INTERVIEWEE: If they are a veteran, I mean Veteran status, they are discharged. For the VA, veteran status means that I have my DD214, and out date, and eligible for health care date. The first thing is they have to have veteran status, or service is through the sharing agreement. Fill out healthcare app, which is a 1010 easy. If they are OEF/OIF combat veteran status do not have to provide their income. Do not have to prove income. They can but it is not a requirement. Those folks are in a special group because they are combat and are getting because they are combat veteran. They don't have to prove income or other things that another veteran might have to. They can tell (administrators) if they are in the combat group. The veteran can walk in or look them up in the VIS system, and look up the DD214 in the VIS system to see eligibility for service. Right now, the medicine service office then schedules the appointment. I believe the goal is within 30 day to be scheduled an appointment.

INTERVIEWER: What is the criteria to be scheduled for an appointment?

C3V–INTERVIEWEE: 1010 easy, and DD214. They submit to the eligibility clerk and they can fill it in online. But if they do it here, they can enroll as of that day they are here. And the information to schedule their appointment is here. When you leave, they have an open chart.

INTERVIEWER: And an appointment?

C3V–INTERVIEWEE: Yes, I think, it use to be where she did some of the scheduling; but now there is an influx and that list goes to another office and they do all of the initial scheduling. They won't always walk out with an appointment, but the medicine office will call and schedule and appointment within the 30 day mark, which I have not seen vary much. Our clinic, post deployment, the majority are combat veterans, OIF, OEF, and Gulf War. Most are current 1999 and up. Our new patient appointment are out 2 weeks in Leavenworth. The only reason it is 2 weeks is because new patient appointments are hour slots and he only takes 3 new patients every day at, 9, 10:30 and 1pm. And I see them and they go through a checklist. It is a form that states who to see and where they are at, for the clinics that are applicable to the individual. It is nice and they get a lot done in one day. Any thing we can do a walk in on we try to as well as behavioral health. And if they need to be seen same day, BH rotates walk in status to be evaluated and talked to and sometimes that may be med management started. That is available. They also take care of the emergency room and they also take appointments.

INTERVIEWER: Is there a baseline on what they have to see?

C3V–INTERVIEWEE: Yeah, if it is a new patient: Labs, EKG based on their age (39 and up) and Primary care doc. All else will be a referral like to the PharmD, if you need your medications explained to you. Pharm D is a walk in and can talk about medications. I think it works smoothly. Every VA is different.

INTERVIEWER: Then what happens after the initial checks?

C3V–INTERVIEWEE: It depends what the patient needs. If the patient has no other needs. After the initial appointment the person is Vested, which means you count. I am not the guru on this, but the way I understand it, is that every vested patient pulls in

dollars to support the facility and keep it open. I don't know the amounts, but the more complex issues, more money that comes in. It doesn't matter if you are seen once, or 35 times, you count and that is the portion that is brought in for the facility. By vesting you are counting for other patients that do not have choices. To stay vested, you just have to be seen once a year. If you are a complex case, than Primary care will make referrals. He will make a consult and that clinic schedules.

TBI consult. We do a Pre-screening, it does not diagnosis, but it is an indicator that you need to be further evaluated. There is a clinical reminders, that the veteran answers questions, and they answer yes, then it will trigger the need for a consult. If that happen, they get referred to the physical medicine rehab clinic to see a rehab doctor to do a level 2 TBI exam. Go through conversation, a 90 minute exam process and at the end they make a determination if the symptoms are related to TBI or mental health. Most of the time, they overlap so much, a lot is the times it is mental health. They can determine that, if symptoms started after the 6 month mark, we know it is very unlikely that it has anything to do with the head injury. People have to be educated. If it is TBI, they will be referred to services like speech pathology, memory enhancement, provide PDAs assisted Apps to help with the memory.

Cognitive rehab through psychology. They always do the evaluation in Nuero-psych testing, where they meet with a psychologist to determine were the deficits are in the retention or working memory.

Discussed the new female clinic–not applicable to the research.

INTERVIEWER: For TBI we are talking more about moderate to sever because if it is mild, then we are saying that it should have already healed or symptoms have already shown and been diagnosed?

C3V–INTERVIEWEE: Mild, moderate, and severe, all has to do with how long on unconsciousness there is. There are different time frames. Most that we see are more of the mild. If they come to us, they don't do the level two cause they are already diagnosed. More of the moderated to severe, we already know what the status is, it is obvious. If they need additional treatment, then we would just refer him.

INTERVIEWER: Since he is already in the System through IDES, eliminating the redundancy, it is already in the system.

C3V–INTERVIEWEE: Right.

INTERVIEWER: On the PTSD side, it is diagnosed, go through the initial appointment, and then do I go to the behavioral health clinic?

C3V–INTERVIEWEE: That could work a couple different ways. First, if the case manager calls the patient or the medboard guy, it may say on his document, MTF referral, than it is checked may say mental health. If I call him/her, I would say, I have your referral, what do you, as the patient, see as your major needs right now. And the patient will tell me. I can then make those referrals. If they say I was seeing psychiatry and counseling. I will confirm what they were doing, and meet expectations per specialty (psychiatry, social work, group). "Every VA is different." I'd give them a basic packet, and what the clinic has found, is that by the patient vesting the time in the initial packet, showed that the patient was actually interested in services. And would use the services better and what they want and need. The wait list went from a couple months to less than

30 days for psycho-therapy. Nothing is driving this paperwork, it is not a mandatory checklist. There is Evidence based treatments, cognitive processing, prolonged exposure therapy, all for a limited time, meant to be short term. Skills and tools to manage life.

Discussed specific groups available. Not applicable.

Back to the Behavioral health. If it is one of my new patients. I will talk to them about what they need. Clarify what service they are looking for, sometimes they are not sure, so I will send them information, or we can discuss it, or we can try new services.

It can look a lot of different ways, there are screens at the primary health clinic appointment. Depression, PTSD, post deployment screen. They will get re-evaluated throughout and help is given immediately if needed. There are a lot of options. If group doesn't work, individual might. Or vice versa. Tailoring it to meet needs.

Information on group therapy was given, which is not applicable to this research.

C3V–INTERVIEWEE: Do you know about the Vet center in Kansas City? It is another option to transition to mental health. So instance, if someone comes in who work from 9-5 cannot make appointments, certain VAs have a branch of the VA small clinic of counselors at the Vet center that provides help with transition assistance. The Vet center is small, not intimidating, and much more flexible. They work with spouses and children, and offer evening group sessions. Offer a lot of groups that are available in the evening. We can refer them to the Vet clinic, but they have to enroll with the Vet clinic, even though they are a part of the VA. They have access to the VA system, but they do not document in it. Patients feel a bit more safe in the vet center. Vet centers are another way to get services another option with a different twist, with just counselors. Another

opportunity to get service in another way at a different time of day, and they have a lot of veteran employees.

INTERVIEWER: As a case manager, what do you do?

C3V–INTERVIEWEE: Everything. We contact the new patients and conduct a pre-screening to begin identifying areas of concern or needs. I can make appointments, or schedule new patient appointment, lab. Determine needs within the VA. Then we also help determine outside services. For instance, financial issues, which can vary, for instance, someone really cannot work. It is not that they do not want to work, but they cannot based injuries. And they are waiting for disability. There is a lag time, by when they get out from the first check from the VA. That process fluxuates and depends. One of the reasons that there is lag time is because, the VA cannot process the claim until the soldier is out and a veteran. The VA can do everything up to that date, but until they get that discharge paperwork, they aren't considered a veteran. I'm not an expert on this, but I think They get the DD214, and then the MTF sends it to the regional office. And the last step is MTF sends it to the regional office and they can finish processing. There are steps after discharge, it has to post and go to treasury, they have to enter it. And everything is done by order of receipt, so if 500 people get out on May 7, you are in the order if 200 got out the day before. There are such a lot of people getting out of the military, there is still a lag time, I am seeing 2 month wait. Most of them are in receipt of their retirement, it is the VA offset hasn't kicked in yet. Which is dependant on their percentage, but it could be a little to a lot more. But we see it as a barrier.

Outside services. Let's say that there is someone who is not receiving anything. They didn't get the medical retirement and nothing has kicked in, even the military

medical. So then we will refer them to services that are specific to the combat vets that can apply for financial assistance organizations, I think it is called stop gap and it is for those who are specific for those in transition from the army to getting disability or getting a job. That is the other group of people, those who have gotten out and may not be service connected and may not have a job, that takes time. Regardless of the situation there is no money for let's say 3 months. A popular organization is USA CARES will provide a something to sustain until payment kicks in. And I will help coordinate with those specific Combat vet sources. They all have different rules, mostly timeframes in which they hold to. After about 12-18 months, they figure you ought to be transitioned. So if you come in four years later than we cannot use those specific resources.

INTERVIEWER: That is a really good point. What do we consider the transition window? Is there a definitive transition window. For at least the outside services is it up to 18 months?

C3V–INTERVIEWEE: I don't there is a window. But yes, 18 months is what a lot of them, like VFW unmet needs do 2 grants in a lifetime, up to 2500 dollars each time and money cap. I know USA Cares caps at $1,000. Each one is going to be different. We will sit down and talk out each situation. We will talk about options for applying for food stamps, army relief loan, Kansas national guard family program. And try to connect them with a service until something comes through to help them make it. And that is one of the questions that we ask to see if they have any immediate resource or financial needs. We also refer and send them to vocational services. They can help with resumes, get back to school, apply to federal employment. We do a lot of referrals.

Let's say that there is someone has a lot of needs: They have Behavioral Health needs, they are not working, and are getting a divorce. There is not a scale of how we determine, but it is subjective on if we need to follow a case. Most people do not need to be followed. If they do then we put them on a care management tracking system. The system is use to track and follow up with people. If I determine if someone is at risk person, Case Manager will follow up and put in the tracking system. Track them monthly, quarterly, weekly, or semi-annually, once a year. Some of the severe cases, comes from MTF with multiple issues, automatically go in the system. The tracking system helps us to remember those who need assistance, and follow up. I'll call them, or check on the calendar who may have an appointment to check up on them. And if they don't come in, I'll phone them. Some have been on the list for a while, sometimes it is a maintenance thing, or they have no support. So that we check in with them and they know that someone cares and is helping them to access or provide resources if needed. It can look intense for one person, but not so intense for another. If it is a new patient, and they have shaky stuff at the beginning, we may follow them for a couple months, until they are engaged. Our main thing is to make sure they are engaged in their care. Our goal is to make sure that the veteran is transitioned with the services that they need and they are accessing the services independently.

Once they are doing that and they are making their appointments to the counselor, psychiatrist, and they can get follow up health care, there is not a lot of reasons to follow them, cause they are doing it themselves. It is the people who cannot do that, that we have to call and check up on. Ask if they need help and follow up with. It may be a

simple answer, but then we can provide alternatives. It depends on the person. And Making sure they are getting services.

Comments on other assistance programs and services that do not pertain to the research.

I also provide group services. We do our own group therapy. It is mainly Case Management.

INTERVIEWER: On average how many people do you have at any one given time?

C3V–INTERVIEWEE: Right now there are 70. But the cases vary, there are mainly Monthly and quarterly and I still have to figure in 3 new patients, walk-in, groups, and MTF referrals. It is the bulk of what we do: make calls and following up with people in the tracking system. They don't have to be on my system to track them. There are a few who come in who still need help, but I don't feel like they need to be tracked, so they will call and need help.

INTERVIEWER: The 70 does not include anyone else. Only in the tracking system?

C3V–INTERVIEWEE: The tracking system I could get in one week, I'll add 3-4 people while others drop out. It changes. In no way is it a gauge of how many people we are in contact with. Because the Panel and clinic has about 700 patients assigned to help through the clinic. Some of them are the 70, everyone else is kinda as needed.

INTERVIEWER: What is guiding principle that says you are going from DoD to VA?

C3V–INTERVIEWEE: Say they are at Fort Riley and they are coming here? That is the Referral. From the LNO it goes to Topeka first, and then sends it to me. I print it off and then we have 7 days to contact them.

INTERVIEWER: Is 7 days be standard, regulation?

C3V–INTERVIEWEE: Yes, it is tracked by department. Then I call them and set up the new patient appointment. Sometimes they can decline too. There is a system of MT to VA, one of the questions is 'what is the result of the contact?" Either out patient appointment was scheduled, or another is declined. I've never seen it happen, but it is a question. If they want to set up services, I've been able to set up the day after final out. We also send welcome packet, letter that explains the VA system, appointments and where to go, and my contact. We send out a brochure about what the VA does. Finally I tell them that if you have any problems between now and then, just call me. We can go over all the options and resources to apply for assistance, because we are here to help.

Unemployment issues. Can't work is different than looking for work. Different category of finance and barrier. The ones who are in the group do not qualify for unemployment. Because to get unemployment, they have to be looking for work. If you are not able to work, then it puts you in a different category and it becomes a different barrier to deal with.

INTERVIEWER: What is successful for a smooth transition for that soldier?

C3V–INTERVIEWEE: The Military treatment referral system in a medboard and if they are at a facility with a LNO. Those typically go smoothly. We know who they are, they have been identified, we have their information, and we know how to get a hold of them. For someone who does not go through a medical board, but they are a combat

veteran, may not know how to enroll. They may not have heard the briefing. They say that they did not hear, but I know they got the briefing. But I know how that works. When the return from combat, they just want to go home. They don't pay attention. Some people still don't know or know how to do it. If they show up and they are identified as a combat vet with the VA department, then the VA will contact.

INTERVIEWER: Is that a Pitfall of the transition process?

C3V–INTERVIEWEE: Yes. I know that the Army and branches, that the soldiers get briefed about the VA, but you still get people who say "I didn't know about that". How do you contact those? I don't know how to contact them if you don't know that they exist. VA tries to spread the word in the community and Outreach events. To see if they are others qualified for VA. It is a mystery why some people don't hear that they need to see if they are eligible for the VA. I don't know how you catch them.

INTERVIEWER: What about those with PTSD and TBI that are going through the transition process, is there anything that they can do to help with the transition?

C3V–INTERVIEWEE: For those with PTSD, it take people up to 18 months before they will even seek treatment, there is a delay in seeking treatment and by then, they have coped in other ways: substance abuse. The delay is because they don't think or don't want to think that something is wrong. Or that they are strong and can do it on their own. They have dealt with it in a different way and coped with drugs and alcohol. The stigma of mental health is an issue that we cannot control on when someone decides to get treatment.

INTERVIEWER: Have you seen cases where they have realized it later on, and it has become successful? What made him successful?

C3V–INTERVIEWEE: Yes, there is a guy that works here as a peer veteran. He went to the Vet center first but now he works with the veterans at the VA to help them. It took him a while, but he is one that I can think of. But I don't know what the turn around was. I think that people just need to be ready to receive. Meet them where they are at. You can't make them do it. If they are not ready to receive the help, then. . . . .I always tell people what is available. Leave the door open and let them know the resources are out there, when they are ready. It is such a small percentage of the veteran population. We are seeing and treating those with problems, which is a small percentage.

INTERVIEWER: What can the VA do to help with a successful transition?

C3V–INTERVIEWEE: Keep doing what they are doing.

INTERVIEWER: What are you specifically proud of? Do well?

C3V–INTERVIEWEE: I called a guy yesterday as a new enrollee. I called and left him a message and sent him information. He called me yesterday, and very excited that VA reached out to him and took the time and effort to contact him. I think that is a huge deal, that we do outreach to people. Not everyone who enrolls wants care. They do it as a just in case, if they need health care. I've been dealing with another gentlemen who has been struggling with problems home and a divorce. I've been the constant. He called and left a message to the case manager and I called him back and now he is all set up with services and is very appreciative. He knew enough that he had to call me, and they keep you in the back of their mind and know that he can contact me for help. They remember that I am the one person they can call when they need help. Because at some point, we connected with them, and that we will help them figure it out. "I knew that

you'd help me" Making a connection, however we can do it, is usually when upon initial contact. A lot of us can connect with people quickly. electronic CPRS social work note.

INTERVIEWER: Is making initial contact dictated somewhere?

C3V–INTERVIEWEE: There is a CPRS, electronic system, we document our social work notes. And we have a template with a narrative that we can talk about what happened and what the plan is and what we follow up with.

INTERVIEWER: Is making contact an issue and why?

C3V–INTERVIEWEE: Yes. Sometimes they don't answer. We have a call 3 time rule and then mail. A lot of the times they don't call you back. People do not respond. They will show up eventually. That is a big thing, just the response.

INTERVIEWER: Is there anything that VA can do better within the transition process?

C3V–INTERVIEWEE: I think it would be fantastic if there were more people to do more. The more staff, the more time people have to invest and to spend time to the things that matter. Contacting new patients is important, but have more people to spend time with them. Do better work if we had more time to do it.

INTERVIEWER: Are there any specific roles/staff that you need?

C3V–INTERVIEWEE: We always need more case managers and Care management. I know it would always be great if we have more mental health, because anytime someone has to wait, is an issue. There are built in things to assist the immediate problems such as walk ins. But more Behavioral Health would be ideal. They are doing a good job filling in the gaps with Walk in and emergency care. Which is nice if someone

is having a crisis. They have built in some safety nets. I think the more people available to help in any part of any organization is going to be helpful.

INTERVIEWER: Are there any concerns that should be addressed? Hand over, finances, support, job employment?

C3V–INTERVIEWEE: I think employment because it is the last thing you said. It is a huge barrier to getting people back on track. We are at a disadvantage with transportation. To get them to and from their job. When I talk with people a lot of them, there issues are they are Under or unemployed. Or they didn't plan ahead or they don't have the money. Financial need is such a huge piece of why they are struggling. And when you are stressed about money, than everything else gets stressed and strained, if you do have Behavioral Health issues, or PTSD, then that gets escalated as well. Finance is a huge issue.

INTERVIEWER: Are those the top issue that you see that trend: Employment and finance?

C3V–INTERVIEWEE: Yes, underemployed, unemployment and finance. And then I'd add, people's own mental health and taking charge to get better. It is a decision, a hard decision, and not everyone is ready to commit to it. To say "I am going to take charge and do what I can to move forward." It would be great if people started with "I'm going to get better, not going to hide, isolate, or take this, but everyone is in a different place." Everyone is in a different place in that. I tell people "You can get better, I 'm not saying you'll get cured, but there is something you can do." I don't know if people initially believe that. It is a barrier for people.

INTERVIEWER: What can a soldier or patient do to improve their chances for a successful transition?

C3V–INTERVIEWEE: Be honest and answer the screenings honestly so that they can get the help they need. If they would take that information and listen to their options and formulate a plan for help to get better and to take charge of their own care and know that they can do it and be successful. They can get better.

INTERVIEWER: Within the VA is set up for the Veteran. Sometimes they can't see a silver lining, are they allowed to have family/spouse with them?

C3V–INTERVIEWEE: Yes, we have a group for family support and care giver support. It meets once a month. No one is going to tell them not to bring their spouse or parents. There are a lot of patients that cannot function well because of their mental illness and the spouse or the parent is helping. The care giver support is really there for the family members to help them through the process as well. As long as it is related to the patient, but remember the vet center will see kids, and spouses, and family, without seeing the veteran.

INTERVIEWER: Is there anything else that you want to mention or contribute?

C3V–INTERVIEWEE: Directly related to what we do as a team, not that I can really identify for case managers. We touch so many things like the Domiciliary, which provides additional support/resources. We are involved in so much, we are embedded in everything, which is a good thing. It is a good thing that people know we are here. One thing we do is we hear a lot about benefit questions and we do education, even though we are not the decider, but we help them understand, get access, and refer. Even though we are not in control of it, we support that question a lot and we try and help them get their

answers through the right channels instead of having them be frustrated with it because it is stressful. We want them to know who to go to, and I can contact someone on their behalf and help them understand the process.

APPENDIX I

X4I-INTERVIEW–OIF/OEF VETERAN, (CPT) DIAGNOSED WITH PTSD, SEPARATED FROM THE ARMY

INTERVIEWER: Are you diagnosed with PTSD?

X4I–INTERVIEWEE: Yes.

INTERVIEWER: Was that in association with a TBI?

X4I–INTERVIEWEE: No. When I was a Company commander, I had family issues and I missed a lot of work and my new Battalion commander was not very understanding of my situation and he claimed my lack of performance at work did not have anything to do with my family issues, but rather with alcoholism. And sent me to ASAP, and through ASAP, I got the mental health help I needed. In the long run it did benefit me, because I was forced to go through counseling and finally brought out all my issues, even after I stopped going to ASAP.

INTERVIEWER: Did ASAP identify other concerns?

X4I–INTERVIEWEE: Yes, it identified that I had anxiety and depression problems so I started seeing the ASAP behavioral health counselor. Then moved on to cognitive processing therapy counselor, where I had to relive some stuff. And then I started going to an army psychiatrist at Madigan, who diagnosed with PTSD and treated me medically. He took my case on himself.

X4I–INTERVIEWEE: Did it help?

INTERVIEWER: Yes and no. It helped talking about it and have someone understand and prescribe me the medication I needed. But I still have anxiety, depression

and loud noises are still issues. I may have a panic attack and it takes me 30 sec to a min to calm down.

INTERVIEWER: Do you think because you are aware of it and can identify symptoms, that you are able to handle the situation better. Did they give you coping techniques?

X4I–INTERVIEWEE: Yes, I can. They didn't help me with coping, I found my own coping techniques. Realizing where I am and calming down. I still have an occasional nightmares, but I am on medication. It takes me a few minutes to calm down. But they helped me talking about life. And he, the doctor, helped me with the transition, just talking about it and recognize my fears with it. Because I was a two time non select for major, I only had 6 months to get out and find a job. I ended up being unemployed for 4-5 months. I met my new employer who recognized that my military skills as a leader and manager would translate very well into his company.

INTERVIEWER: Upon being diagnosed with PTSD, what that part of your transition?

X4I–INTERVIEWEE: I found out years ago, 2011, that I had PTSD.

INTERVIEWER: You were given six months to complete everything. What is everything?

X4I–INTERVIEWEE: The ACAP process. And while I was doing the ACAP process I was still fully integrated in work. My boss, forced me to start the ACAP process because I was dragging my feet on it and did not want to accept it. He told me to go to ACAP. Basically you go through 5 mandatory briefs and get stuff in order, finalize ORB, officer record brief, to make it transition onto DD214, get it set and right. Transition to

the reserves because I was given $70,000 separation allowance if had a reserve contract. It Helped during my unemployment time and it set up soldiers and the Army is doing what they can to help the soldiers financially for a little while.

INTERVIEWER: Besides ACAP where there any other programs you used?

X4I–INTERVIEWEE: No. I went to Job fairs for ACAP. Job fairs appear to be mostly sales positions. As an Infantry man, I'm a jack of all trades, a master of none. So I have no engineering or IT experience. My main thing I bring is a leadership managerial background. It is difficult for an infantryman. Signal and MI backgrounds have a big upper hand.

INTERVIEWER: Did you think that your PTSD affected your transition?

X4I–INTERVIEWEE: A little because my anxiety was high and had a hard time to focus on the next step.

INTERVIEWER: Did you have any major incidences during your transition?

X4I–INTERVIEWEE: No. Not really. It was just an additional stress that raised my anxiety levels and I was going through a divorce at the same time.

INTERVIEWER: Being completed with a transition, what are some successes with the transition program?

X4I–INTERVIEWEE: They give you a lot of briefs and a lot of tools. Which is fantastic, however it is also very overwhelming. I am still pulling paperwork out of the back of my truck. There is so much stuff, a whole lot all at once. It is organized, but ACAP is a year long process and I had to do it in 6 months. It was a lot to digest. If I had a full year, it would have been fantastic because I would have been able to organize my thoughts better, and organize the literature that they give you.

INTERVIEWER: So you don't think that 6 months was enough for your transition?

X4I–INTERVIEWEE: No, not at all. And the Army doesn't think it is either, but that is what happens for a non-select. If a soldier is going to refrad and just get out, the Army suggests that they start planning a year out.

INTERVIEWER: When a soldier gets medically boarded, they get 90 days. Do you think that is doable?

X4I–INTERVIEWEE: I know a soldier who has been in the medboard process for 2 years at the WTU. And they can start that process ACAPing simultaneously, have a lot of time to get stuff in order, before the 90 days begins. So they can mentally prepare but they can also start the process. Cause if you start a medboard, he knows he is getting out medically, you can start the ACAP process too. But the medboards, they have a little bit of a benefit, cause if you complete the medboard cause you get disability from the Army and from the VA.

I had stacks of paper and made my truck into a mobile transition center. I'd be like where is my finance paper, or the form I have to give to the transition center. There needs to be a filing system and label it properly.

INTERVIEWER: Are there any other positives to the transition?

X4I–INTERVIEWEE: Yes, look at the transition now and 10 and even 5 years ago, the Army completely revamped the ACAP process. They realized that there were a lot of us getting out and they weren't getting the proper information.

INTERVIEWER: What are some of the Major pitfalls within the process? Tailor it to those diagnosed with behavioral health concerns, how do they make it better for them as well?

X4I–INTERVIEWEE: The one I can tell you is the VA brief. It is a Day long brief, no one wants to be there, even though it is important. I paid attention, and I knew I needed medical assistance once I got out; however it was very condensed and no personal interaction or standpoint to tailor it to the soldier. The VA brief is good overall, there needs to be specific one on one time needed. I got transition assistance for 6 months of full coverage under TRICARE, and didn't remember or know how to do it. When I was filing my claim, and talking to a lady at the American Legion, she was the one telling me what I needed to do and how to make an appointment. Once I did that, I still haven't had my initial appointment. It was two months to see a doctor.

INTERVIEWER: So you are still waiting to see a doctor?

X4I–INTERVIEWEE: Yes.

INTERVIEWER: When you called to set up the appointment, did they tell you it would take that long?

X4I–INTERVIEWEE: Well I had to go in. I went in, filled out registration paperwork and set up my appointment. But it was going to take 6 weeks. When I transitioned out I had major spinal surgery and I was still covered under my 6 months of TRICARE, I'm having complications, and now I can't see a doctor. I also have the TRICARE reserve, but the reason I'm waiting is because it has co-pay and if I do it through the VA it is free because it is a pre-existing condition. So I have to wait another four weeks. However in the PTSD side, I have my prescriptions renewed by doc before I

out. Called in for refills and the VA still filled them, which will get me to my appointment.

INTERVIEWER: How long did it take you to get plugged in with the VA.

X4I–INTERVIEWEE: 6.5 months. Cause I was still covered for 6 months with TRICARE prime. So I didn't really think about it or know about it until I filled my claim, cause I was still adding to my packet.

INTERVIEWER: And if you knew that it was going to take this much time, you would have started earlier?

X4I–INTERVIEWEE: Yes. The other issue for me was that I was still adding to my medical records cause I still needed spine surgery. It took me a long time to file my claim and the American Legion was very helpful with that.

INTERVIEWER: Did the VA call or contact you?

X4I–INTERVIEWEE: I got a letter rubber stamped from General Shinseki, outlying my authorizations, but it did not explain how to do anything.

INTERVIEWER: Did Tacoma VA not call you?

X4I–INTERVIEWEE: No, nobody.

INTERVIEWER: Then it was left up to you to make these connections?

X4I–INTERVIEWEE: Yes.

INTERVIEWER: Are you finishing your claim?

X4I–INTERVIEWEE: My claim is in the system and sent it up to Seattle. They told me it was going to be 9 months before I receive disability. And that $70,000 I am going to have to pay that back. It is a loan if you are going to file a claim. The Army will

recoup that money out of your VA disability benefits. They made that very clear at the VA brief, and upon applying, and filing the claim.

INTERVIEWER: You are just on the initial part of the VA, What are your observations of the transitioned into the VA?

X4I–INTERVIEWEE: VA workers are kind, warm, and helpful, willing to answer questions. The backlog on appointments and benefits are a nightmare. I was talking to another guy if the VA was helpful, and he said yes, however, "takes forever to get anything done."

INTERVIEWER: What can soldiers do that might make it easier?

X4I–INTERVIEWEE: Soldiers need to realize they need to get in the mind set and start thinking ahead of time. I swore up and down that my letter to the president of the board was going to work and I was going to get promoted to major, but I should have had it in the back of my mind that if it doesn't go through, I need to start planning now, and I didn't. If you think you are not going to get picked up you need to start planning ahead of time. You need to get yourself in the mindset, you need to get your resume together. In ACAP I wrote a great resume based off their model, but every person I talked with in the business world said it was crap. My brother took my information and formatted it into a sterling resume. We all have good qualities and great experiences, you need to talk to a subject matter expert and the ACAP people are outdated. They do give you a class on how to translate your military career into civilian speak.

INTERVIEWER: How important is it for your leadership to help in the transition process?

X4I–INTERVIEWEE: Extremely important. I was dragging my feet and my boss said you need to start doing this right now, and he kicked me out to complete the process.

INTERVIEWER: He allowing you the time, did he provide any other support?

X4I–INTERVIEWEE: He did, he got me connected with my next reserve National Guard job. Discussed National Guard opportunities that did not pertain to this research.

I think Leaders in general at the company command level need to take and develop company commanders on how to assist soldiers going through ACAP to understand what needs to be done. As a company commander, I had soldiers ACAPing, and I didn't understand the process. But they really need to lay it down for commanders.

INTERVIEWER: Did transition into the reserve help?

X4I–INTERVIEWEE: Yes, because I got depressed when I took off the uniform. The Army defined me for so long and not having the uniform on depressed me. Getting in the reserve unit, helped motivate me to continue to move in a positive direction.

INTERVIEWER: What advice would you give a PTSD transition person?

X4I–INTERVIEWEE: Talk to friends and family who are in the civilian world and have written resumes and how to translate military experience into civilian experience. I was very glad that my brother helped me. And Start as early as possible going through the ACAP process. There is just so much to take in all at once.

INTERVIEWER: Anything else?

X4I–INTERVIEWEE: No.

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